PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue NW
Washington, D.C. 20004

Thursday, October 25, 2018
9:32 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
ALAN WEIL, JD, MPP
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:32 a.m.]

CHAIR THOMPSON: Okay. Why don't we go ahead and get started.

Welcome, everyone, to our October meeting. We're going to kick off the day with a discussion of DSH, and our first session is going to be presenting updated analysis on the relationship between allotment and certain measures defined in the statute. And we have Rob and Madeline to walk us through this.

REQUIRED ANALYSES OF DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS

* MR. NELB: Okay. Thanks, Penny. We have a double dose of DSH today, your favorite topic, and we're going to begin by reviewing some of the data that we are required to report annually.

I'm actually going to turn it over to my colleague, Madeline, who does the work in compiling all this data, and she's going to walk through all the different data elements we're required to pull, which are listed here. We're really going to focus on some new data that we have about amounts and sources of hospital

uncompensated care, using new data from 2014 DSH audits, which finally start to give us some information about how Medicaid shortfall has changed as a result of the ACA.

So I'll turn it over to Madeline and then I'll talk about some next steps for pulling this together for the March report.

* MS. BRITVEC: Okay. Great. Let's begin with the number of uninsured. We gathered from the Current Population Survey that 28.5 million people or 8.8 percent of the U.S. population were uninsured in 2017, which showed no statistical difference from 2016. About a quarter of the uninsured individuals have incomes below 100 percent of the federal poverty level and about half of them had incomes under 200 percent of the federal poverty level.

From 2013 to 2014, the number of uninsured decreased by 13.3 million, a 32 percent decrease, with larger declines in Medicaid expansion states.

Secondly, we'll look at uncompensated care. Throughout our research, we used three main data sources, each with their own strengths and limitations. MACPAC used the Medicare cost reports to access information on all states and that defines uncompensated care as charity care

and bad debt. We used the Medicaid DSH audits to provide accurate information on DSH, but the data is not timely. We are presenting data from 2014.

DSH audits define uncompensated care as unpaid cost of care to the uninsured and Medicaid shortfall, which is the difference between Medicaid payments and the cost of providing those services.

We used the AHA annual survey to compare our findings on Medicaid uncompensated care, but it does not provide state-by-state information, only national data.

Alright. There were slight changes in Medicare cost report data from the previous year. According to the Medicare cost reports, $35 billion went towards uncompensated care, and that is 3.6 percent of the nation's total hospital operating expenses. And this $35 billion is an 8 percent decline from 2015.

About 60 percent of uncompensated care went towards charity care and 40 percent went towards bad debt expenses. States that expanded Medicaid under the ACA in 2016 experienced larger declines. And in past year we've compared recent findings to the 2013 Medicare cost report data. However, this year we are unable to do so due to

recent definitional changes in the Medicare cost report instructions.

DSH audit data also shows change. To compare years, we reviewed uncompensated care costs reported for the subset of hospitals that were included in DSH audits for both the state plan rate years 2013 and 2014, which was 92 percent of all hospitals in state plan rate year 2014. The state plan rate year aligns with the state fiscal year so that's about half a year of expansion.

And what we found was quite surprising. The increase in Medicaid shortfall was larger than the decline in unpaid costs of care to the uninsured between 2013 and 2014, so much so that the DSH uncompensated care increased in both expansion and non-expansion states.

This figure shows uncompensated care for DSH hospital by expansion status. As expected, DSH hospitals in expansion states experienced a decrease in unpaid cost of care for the uninsured, but what's unexpected is this increase in Medicaid shortfall. Medicaid shortfall in non-expansion states showed a similar trend, and overall the reduction in unpaid cost of care for the uninsured is outweighed by the increase in Medicaid shortfall.

So when compared with other sources, the decline in unpaid cost of care to the uninsured makes sense. However, the increase in Medicaid shortfall is a little bit more difficult to explain. Medicaid cost reports show hospitals reported a $5.7 billion decrease in uncompensated care between 2013 and 2014, and this is a lot larger than what we found in our DSH audit data, the $1.7 billion. However, when considering that DSH audit data includes DSH hospitals which are half of all hospitals, and accounts for half of the year of expansion, this starts to make a little bit more sense. The subset of DSH hospitals in our analysis reported a $3.5 billion decline in uncompensated care on Medicare cost reports, which is about twice the amount they reported for the first half of 2014 on DSH audits.

The AHA annual survey reported a $0.9 billion increase in Medicaid shortfall between 2013 and 2014 for all hospitals, which is much smaller than our DSH audit findings. It's a little bit harder to explain, and yet we will try.

To understand the change in Medicaid shortfall more clearly we looked at the components of Medicaid

shortfall, and as a reminder, definitionally, Medicaid shortfall is the difference between a hospital's cost of providing services to Medicaid patients and the Medicaid payments received for those services.

So Medicaid payments include base payments, which are tied to services, and non-DSH supplemental payments, which are not. Medicaid expansion states experienced a 10 percent increase in base payments, which makes sense due to the increase in enrollment, and non-DSH supplemental payments did not change.

Expansion states saw an increase in Medicaid payments, but comparatively that percent change was lower than the increase in Medicaid costs, showing that Medicaid costs are more than Medicaid payments.

So in addition to the variation between Medicaid expansion and non-expansion states there is also variation amongst all states. This graphic shows Medicaid shortfall as a share of uncompensated care costs for DSH hospitals. Nationally, Medicaid shortfall was 33 percent of the total DSH uncompensated care, with only a few states experiencing shortfall having a share of over 75 percent. Fifteen states did not report Medicaid shortfall and 14 states

reported shortfall that exceeds 50 percent of their total DSH uncompensated care costs.

Lastly, we will turn to essential community services. The term "essential community services" is not defined with Medicaid's statute or regulation. MACPAC has created a working definition based on suggested services and statutory provision and the limitation of available data. In our working definition we start by identifying a deemed DSH hospital, which means a hospital that serves a particularly high proportion of Medicaid or low-income patients. These hospitals are required to receive DSH payments, and in 2014 there were 832 deemed DSH hospitals.

Ninety-nine percent of those provided at least one essential community service, 94 percent provided at least two, and 83 percent provided at least three essential community services.

MR. NELB: Thanks, Madeline. So as you can see we got a lot of updated data, and our plan to pull this together for the March report is to come back to you in December with a full draft chapter that includes this data, as well as some of the other contextual factors about DSH that we normally provide, about the characteristics of DSH

hospitals. And then we plan to include that in the March report.

I'm happy to answer any questions you have on this session before we continue on round two of DSH.

CHAIR THOMPSON: Okay. We have Martha starting us off.

COMMISSIONER CARTER: One thing that puzzles me is the difference in how the DSH audits capture a certain set of data and the Medicaid cost reports, and that's the cost of care for people who are insured but have bad debt, right? So is there any way to know that impact as we have more availability of high-deductible plans and, you know, now new on the market these short-term plans that are not going to cover as much? Is there a way to sort of scope out if that's part of, you know, the difference we're seeing?

MR. NELB: Sure. So first just to clarify the differences between the two sources. Medicare cost reports include bad debt and charity care for people with insurance as well as people without insurance. DSH audits mostly include bad debt and charity care for people who are uninsured. However, it also includes people who are

uninsured for a service, so if your plan didn't cover a particular service, then even though you have insurance you're still considered uninsured for that service.

COMMISSIONER CARTER: Well, if it covered the service but you have a $5,000, or whatever, $10,000 deductible, where does that fall?

MR. NELB: Yeah. I want to double-check to make sure I'm right on the specifics but there are some cases where some of those patients may be included if they've like reached a limit or something I think they may end up being included in the DSH audit. So I'll double-check and can get back to you on that.

So, yeah, there are some differences between those and there is some data we can get to, to sort of approximate some of the bad debt for people with insurance, but we don't have full hospital-level data to use that to fully explain the differences.

CHAIR THOMPSON: Okay. Stacey.

VICE CHAIR LAMPKIN: I have a couple of questions. Thanks. This is really good stuff. My questions also go to what the dollars on the various reports represent. In either the Medicare cost report or

the DSH audit concept of uncompensated care, or unpaid cost of care for uninsured individuals specifically, is there any kind of income threshold at all, or you're uninsured, you're uninsured no matter what your income is? That's my first question.

MR. NELB: Yeah. There is no income threshold.

VICE CHAIR LAMPKIN: In either source.

MR. NELB: Correct. Often times for charity care hospitals will have a charity care policy that does specify a certain income for that, and so that may distinguish whether they end up being treated as a charity care or bad debt, but either way they're included, regardless of their income.

VICE CHAIR LAMPKIN: So there could be some inconsistency, hospital to hospital, in how dollars are reported as bad debt versus charity care, based on the hospital's own policy with respect to categorization.

MR. NELB: Correct, but under all circumstances that patient would be considered uncompensated care under both sources.

VICE CHAIR LAMPKIN: That's helpful.

My second question is, is there a Medicare

shortfall concept that's actually measured and considered as part of Medicare DSH, or is that truly just a Medicaid animal?

MR. NELB: So as if one DSH wasn't enough, so Medicare also has a DSH program that uses the same acronym but it's different rules. The policies for that are the ACA sort of split that into two parts. One is an uncompensated care fund, which is based on the charity care and bad debt that's reported on the cost reports, so that's for the uninsured.

There is a piece of Medicare DSH that continues, which is sometimes considered to be the empirically justified Medicare DSH. It in some ways is intended to pay for Medicare shortfall, but the payments out of that are based on sort of this historic formula that Medicare DSH has used, which is actually based on the number of Medicaid patients that a hospital has. But it's basically trying to get at hospitals that maybe serve a lot of duals and also disabled individuals, recognizing that they may just have higher costs of care that maybe don't get recognized in the Medicare payment formula. But it's a different concept of shortfall than what we use in Medicaid for calculating

Medicaid shortfall.

CHAIR THOMPSON: It's almost like a proxy for risk.

EXECUTIVE DIRECTOR SCHWARTZ: It's what is considered to be Medicare's share of these other costs that aren't covered, that is, Medicare will help kick in for some of those and not relative to what Medicare paid itself.

VICE CHAIR LAMPKIN: Yeah, that's really helpful, I think, to understand, as we kind of also think about what DSH might mean to Medicaid in the future, when we get to the next section. But it sounds like you're saying that there is some bifurcation of Medicare DSH, where there is a portion of it that is strictly related to uncompensated care for uninsured individuals -- for charity care, basically, stuff.

MR. NELB: Yeah. So this was under the ACA, Medicare DSH got reduced as well as Medicaid DSH, but the way Medicare DSH was reduced was that the funds that were going before, for Medicare DSH, kind of got divided into two parts. One part continues at the old formula, which is sort of based on this Medicaid and disabled patient volume.

The other portion goes to hospitals based on their uncompensated care costs. And then the total amount of funds in that sort of second pool is tied to the uninsured rate nationally.

So, yeah, in some ways like Medicaid DSH pays for both Medicaid shortfall and the uninsured. Medicare DSH, you know, you can conceive of did both, but they sort of bifurcated it and they now have different names, which we can also get into in our report.

VICE CHAIR LAMPKIN: Thank you.

CHAIR THOMPSON: Okay. I'll come back to Martha in just a second. Can I just ask about Medicaid shortfall? So let's talk about that for a few minutes and what we make of that. And my question is do we hypothesize that it's a function of volume, which is the more Medicaid-covered lives you have the more possible shortfall you come up with. Do we hypothesize that it's a matter of rate-setting for managed care, which is that we're seeing some maybe inadequacies around rate-setting, or do we hypothesize that it's about the cost of the expansion population being greater, perhaps, than anticipated, or something else? And do we have any way of parsing any of that?

MR. NELB: Sure. So I can take a stab. You know, as Madeline said, we are sort of puzzling over this data as well. So there is a piece that's due to costs, right, because we saw that cost increased by more than payments in both expansion and non-expansion states. But costs are driven by a number of different factors and we don't have the data to kind of get into exactly why the costs are changing.

So in some cases the costs may increase because of increased volume. They could also increase because of the intensity or mix of services -- maybe these new patients were more complicated to treat. It could also increase just because of overall cost of the hospital and just efficiencies in general. So there are different drivers in there.

But I think we did see the cost piece is a key part of that equation. And, you know, the payments increased --

CHAIR THOMPSON: Can you just stop there?

MR. NELB: Yeah.

CHAIR THOMPSON: When you say now we saw that costs were a key part, I mean, I don't know to separate

cost from the other things that we're talking about, right, because it's all inputs to cost, as opposed to independent elements about how the hospital operates or how it's structure or how many employees it has, or those kinds of things. So can you just say more when you say it seems like it's more about costs, in terms of how you think about that term, in light of what we --

MR. NELB: Sure. So I think costs, again, are a factor that's driven by many different pieces of, you know, utilization, mix of services, and just overall facility costs. I guess, you know, we looked at what we saw in between '13 and '14 and looked at how it compared to what DSH hospitals reported between 2012 and 2013, and saw that, I mean, that the payments increased more in '14 because of increased coverage. So in some ways the payments have improved but they haven't increased at the same rate that the costs did.

So payments are still that other factor of the equation, right, because shortfall is the difference between cost and payments. Here I think we saw that because payments are sort of divided between these base payments and supplemental payments that the base payments

automatically increased sort of when you have more utilization but the supplemental payments, at least for DSH hospitals --

CHAIR THOMPSON: May not. May not.

MR. NELB: -- may not, yeah.

CHAIR THOMPSON: They could.

MR. NELB: They could, yeah, and vary by state. So we're puzzling over it, for sure, but we take your comments into consideration and we can think of how to better articulate some of the different drivers, and even if we don't know which one is the main one we can at least say that these might be some of the big factors at play.

CHAIR THOMPSON: Okay. I have Martha, Fred, Sheldon, Brian, Chuck, Kit, Bill. But Brian, are you saying you want to jump in exactly on this point?

COMMISSIONER BURWELL: The non-DSH supplemental payments are another driver in Medicaid shortfall, and in Slide 11 it's clear that the non-expansion states have lower base payments but higher non-supplemental payments. So that's an interesting dynamic, in my view, so why the shortfall is smaller in non-expansion states than in expansion states.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: I was going to try and abstain from commenting on Medicaid shortfall, having done it in the past, but to the question you raised, Penny, I think it would be useful to think about cost as driven by units and cost per unit. And it's the units being affected by the expansion and maybe changes in the population, and the unit costs are being affected by what the hospital is potentially doing with respect to how they're treating people. And if we could have data to separate that, it would be instructive.

CHAIR THOMPSON: Am I not right that there is some information or suggestion that maybe the intensity of care or the complexity of care needed by the expansion population is greater than what people may have anticipated? Or what do we know about that?

MR. NELB: Yeah, so we do know a little bit about some of the mix of services for the expansion population being a little different from the previous population, and we're reviewing different literature reviews we're doing to kind of compile that, and so we can take a look and then match that with what we know about whether those services

are sort of more expensive or less expensive.

CHAIR THOMPSON: Because just to your point, Bill, about, you know, the units times the cost and what's in that cost, is it really just hospital driven, or is it also population driven?

COMMISSIONER SCANLON: And you can define units as either patients or adjusted patients, which would reflect severity.

CHAIR THOMPSON: Yeah. Okay. Let's circle back. So now we have Martha, Fred, Sheldon, Chuck, Kit.

COMMISSIONER CARTER: I think you're really -- you've already said to some extent what I wanted to try to say, but I wanted to sort of put a primary care perspective on this. You know, we really -- and coming from a state that has a high percentage of Medicaid shortfall, we certainly saw a lot of people who were not getting care prior to expansion, and not just hospital care but hospital-based testing, so preventive care -- colonoscopies, mammograms, things that would probably show up in hospital rates, I assume, that weren't there before. So I'm not sure how to try and regulate that, you know, how to get to that information, but that's the experience on

the ground.

CHAIR THOMPSON: Fred

COMMISSIONER CERISE: I am thinking of the shortfall question myself and trying to understand better. Does the variation among states where you had so many states report no shortfall and then it swings up to huge shortfalls, do you have any sense for what's behind that?

MR. NELB: Sure. So one piece that's important to know applicable to a state like Texas is that the shortfall includes the base payments as well as the non-DSH supplemental payments that they make. And so some states sort of pay for shortfall by -- well, some of these states have high base rates, and so, you know, that's one way to do it. But there are also some states that are in that no-shortfall category that have very high supplemental payments. But whether it's UPL or a waiver payment they're making for uncompensated care, they sort of pay for shortfall a different way rather than using DSH payments to pay for shortfall. So that's one piece, and we can look more at particular states if you have questions.

CHAIR THOMPSON: I think that's an interesting point, Fred, because maybe one of the ways to try to unpeel

the onion is to dive in on an individual state where we've seen some of these changes and try to understand what happened in that case, and maybe if we have a few of those, we can see if we have, you know, complete variation on what's happening at any given point in time because of the connection of all these different factors that we're talking about or whether we see some commonalities. That might be a helpful way to understand what's going on.

Sheldon, Chuck, Kit.

COMMISSIONER RETCHIN: Let me start off with my best Yogi Berra impression. I really do think this is so complicated that if you've seen one state, you haven't seen one state. But, nonetheless, there is so much variation out there. I just want to point out that in terms of the surprise element that Medicaid shortfall would outstrip the reduction in uncompensated costs, I don't think there's any surprise at that at all, and it was predicted by Kate Neuhausen before the ACA was implemented. And that's really because, prior to the ACA and the expansion, the DSH payments to deemed DSH hospitals, particularly the large ones, was based on -- it wasn't based on the market or Medicaid policy. It was based on costs or some percent of

costs. Many hospitals, including the one I was at, were getting in excess of 9 percent of costs. The Medicaid substitution, we knew would drop us -- the shortfall would way outstrip the advantage, quote-unquote, we would get from the increase in the expansion.

The one last thing I guess I would say would be that -- I've said this for many years, and it goes back 20 years when I visited the Medicaid program in Washington to say that I still think that the DSH payments -- I know the original reason for the DSH payments, but that the concentration on hospitals in terms of payment I think is misguided and leads to perverse incentives for hospital behavior and hope that we would as a Commission come back to review the California global payment mechanism. It may be complicated, but I think it's the right thing to do.

CHAIR THOMPSON: Chuck and then Kit, and then we'll wrap up this part of the conversation.

COMMISSIONER MILLIGAN: So just a couple of questions. For the cost reports, are the hospital costs audited or are they self-reported? So in terms of what costs are reported in the cost reports, how much scrutiny is given to those costs in terms of whether the hospital's

efficiently run? I'm curious about whether it's self-reported or audited or how the cost reports are constructed.

MR. NELB: So cost report data are not audited, but the DSH audits are. I think they -- however, the cost report data are used in different Medicare payment calculations, and so there is some level of review for it. I think it's less of a question about whether the hospital's run efficiently, and it's more of a -- you know, they just add up all the costs of the hospital in different cost centers and then use that to sort of figure out the costs that were spent on particular services. So it doesn't give you a view whether those costs are too high or too low, but, you know, it -- so, yeah, for better or worse, though, cost reports are sort of routinely used, even on the DSH audits, or just other ways for capturing data on hospital costs. So it's not perfect, but it's sort of the best approach that we have.

COMMISSIONER MILLIGAN: Part of the back to the future that I'm experiencing is Boren Amendment. I'm looking at Bill. You know, there's a notion when we talk about shortfall that Medicaid ought to be paying costs, and

Medicaid stopped doing that in 1997 with the Balanced Budget Act because it wasn't perceived to be a way of driving incentives to be efficient. And at least at that time, when Medicaid was obligated to pay hospital costs, at least at that time it was audited costs so that you weren't paying for things that were perceived to be excessive costs or self-reported costs. So I just -- it is to me a weird dichotomy between the fact that Medicaid long ago stopped paying hospitals based on costs, but yet we still talk about Medicaid shortfall being relative to costs.

CHAIR THOMPSON: Kit.

COMMISSIONER GORTON: Thank you. A brief extension of Martha's comments from the perspective of a health plan. Pretty common to see newly insured populations consume services at higher rates because they have this warehoused need. What I wanted to add to what Martha said is you usually see that go away. You talked about having six months' worth of '14 data. It may be interesting to watch what happens as things play out and not all the states rolled into the ACA at the same pace, and so we'll have to be careful because they will see their humps at different places. But pretty typically you see

this sort of six-month growth, and then as the populations get under management, they come down to a more reasonable level. So I would just keep your eye open for that.

Then the last piece I wanted to share, Massachusetts has paid a great amount of attention over the last few years about total cost of care, and I think people know that, in fact, we have a legislatively mandated cap on how fast total cost of care can grow. In the last couple of years, the commercial and Medicare segments have stayed within the cap. It was Medicaid unit cost pressure that pushed it up, and you might chat with the people at the Health Policy Commission to ask why they think that was the case. That may give you other factors to include in your noodling. But I think that Bill's point is spot on. You have to think about unit cost and volume in two very different ways. And as you think about unit cost, one of the things to think about is the hospitals do experience huge cost pressures because they have got to buy a lot of stuff. They have to buy all these biologicals. They have to buy all of this equipment. They have to buy all the implantables and all of those other things. And to the extent that we can illuminate a little bit what are the

factors that drive unit cost for the hospitals, which may help us illuminate what are some of the other growth drivers. You know, we've paid a lot of attention in the Commission in terms of prescription drug costs. I think that's true in biologicals. I think it affects hospital costs. But I think medical devices, implantables, those sorts of things are also other incredible, sort of under-the-cover drivers of hospital costs.

CHAIR THOMPSON: Good. Great suggestions.

Okay. So we're going to now turn to the second part of our double dip on DSH. Stacey is going to take the gavel on this part of the conversation.

POLICY OPTIONS FOR STRUCTURING DSH ALLOTMENT REDUCTIONS

* MR. NELB: All right. Great. So we're back for more. For our next DSH presentation, we're going to take a closer look at DSH allotments themselves and some policy options to better distribute reductions among states.

I'll begin by providing some background about current DSH reductions and about why we began this work in the first place to look at ways to better rebase allotments based on factors of need. And then I'll review some of the

specific rebasing factors that we analyzed and how the rebasing scenarios compare to policy goals that the Commission has previously articulated.

Ultimately, I'll be asking for your feedback on several decision points listed here. In particular, hoping to get your feedback today and your thoughts on sort of which measure would be best to use to rebase allotments.

Today is also the time to raise if there's any other design features you think the Commission should consider and particularly raise if you have any thoughts about the assumptions that we made about how quickly rebasing should be phased in and sort of how to phase in between the current scenario and the rebased one.

Based on your feedback today, we plan to come back to you in December with a full package of DSH recommendations, and hopefully we'll have enough detail that we may be able to get a score from the Congressional Budget Office, and then our plan is to vote on recommendations no later than the January meeting so that it can be included in the March report. So lots of good work ahead.

First, some background. DSH payments, as we just

talked about, are statutorily required payments that help offset two types of uncompensated care: Medicaid shortfall and unpaid costs of care for the uninsured. DSH payments are limited by federal allotments, and these vary widely by state based on state DSH spending in 1992 when DSH limits were first established.

The ACA included reductions to DSH allotments under the assumption that increased coverage from Medicaid expansion and from health insurance exchanges would help to reduce hospital uncompensated care costs. These reductions were initially scheduled to take effect on 2014, but they've been delayed several times.

Under current law, DSH allotments are scheduled to be cut by $4 billion in 2020 and $8 billion a year in 2021 through 2025. This is more than half of states' unreduced allotment amounts and is about 5 percent of total Medicaid hospital spending.

Under current law, allotments are scheduled to return to their higher unreduced amounts in fiscal years 2026 and subsequent years.

The statute specifies several factors that CMS is required to consider to distribute DSH allotment reductions

among states. Most notably, CMS is required to apply larger reductions to states with low uninsured rates and larger reductions to states that do not target payments to hospitals with high volumes of Medicaid patients or high levels of uncompensated care.

Last year, CMS proposed a methodology based on these factors. Specifically, CMS proposed distributing about half of reductions based on the uninsured factor and about half of reductions based on the targeting factors. MACPAC commented on CMS' proposed methodology in August of 2017. However, because this was a proposed rule, our comments were sort of limited to regulatory changes that CMS could make. We didn't talk about any statutory changes to the factors that are used.

The Commission has long held that DSH payments should be better targeted to the states and hospitals that need them most, and in our prior work, we found that, unfortunately, the way that DSH reductions are currently structured, they don't do very much to achieve these goals. And so as a result, the formula preserves much of the existing variation in DSH allotments and is unlikely to improve the targeting of DSH payments to providers.

This may seem a little counterintuitive, but, you know, it comes down again to how the allotments are structured. So even those there is a factor in the reduction methodology for the uninsured rate, the methodology doesn't actually improve the relationship between DSH allotments and the number of uninsured. And, similarly, even though there are these factors related to the targeting of DSH payments, it's unlikely that the way that they're structured is actually going to change the way that states target their DSH payments in the future.

And so as a result, when we talked in September about a variety of different DSH recommendations that we could make this year, most Commissioners seemed interested in exploring a new way to structure DSH allotments rather than making further tweaks to CMS' methodology. In particular, Commissioners were interested in gradually rebasing allotments based on measures other than historical spending. This would require a statutory change, and so it provides an opportunity for the Commission to think a little more broadly than it did when commenting on the proposed rule, so we can think of various changes to the statute. However, for this exercise, we are assuming no

change in the total amount of reductions, so that the Commission's recommendation doesn't increase federal spending.

Because 2020 reductions are scheduled to take effect in October of 2019, we set a goal of voting on specific recommendations no later than the January meeting so that they can be included in the Commission's March report.

Okay. So to help kick off your discussion about rebasing, we've analyzed the effects of rebasing allotments based on three different factors that are related to the number of people in a state likely to have uncompensated care costs. We looked at using the number of uninsured individuals in a state, the number of Medicaid enrollees and uninsured individuals, and the number of non-elderly low-income individuals in a state.

Here we defined low income as 200 percent of the federal poverty level, which is the statutory definition of low income used in the CHIP statute, and as Madeline mentioned, about half of uninsured individuals have incomes below 200 percent of poverty, and 200 percent of the federal poverty level is about $50,000 for a family of

four.

We considered basing allotments based on the amount of uncompensated care in a state, but as we discussed earlier, the available data have several limitations. So we could use Medicare cost report data, but it defines uncompensated care differently than the definition used for DSH, and those data aren't audited. And then we could use DSH audit data, which, you know, do use the DSH definitions but they are lagged, and they're only limited to DSH hospitals.

So in order to estimate the effects of some of these different scenarios that we're interested in, we had to make several assumptions about how rebasing might work in practice. These assumptions are really for illustrative purposes, and so if you have thoughts on other ways, other assumptions we should make, you know, let me know.

First, because hospital costs are affected by the cost of care in different geographic areas, we adjusted all the rebasing factors based on the Medicare Wage Index to account for different labor costs in different areas. And, second, we assumed that rebasing would be phased in gradually, and this was really to minimize the reductions

for states that have allotments that are much higher than their rebased amount.

Your materials go into all the different assumptions that we made. I just want to highlight four for you here.

First, we assumed that DSH reductions would be extended throughout the entire CBO budget window, which would provide savings that could be used to phase in DSH reductions over four years rather than two.

Second, we assumed that DSH reductions would be applied to unspent DSH funding first to minimize reductions to states that are currently spending their full allotment.

Third, we assumed that there would be -- when you're doing the rebasing, we assumed that there would be sort of smaller increases to states with allotments below the rebased amount to sort of phase that in a little more gradually.

And, finally, we set an upper bound on state DSH reductions at 30 percent a year in order to just minimize disruption for those states that have allotments that are much higher than the rebased amount.

This figure illustrates the four-year phase-in of

DSH reductions that we're assuming. As you can see, under current law DSH allotments go until 2025. We're proposing to extend that until 2028. CBO estimates that doing so would result in about $6.3 billion in federal savings, and so we think that this could be used to phase in reductions over four years rather than two. Of course, the full effect of any proposal will be contingent on all the other pieces of our recommendation.

Okay. So with that background, let's talk about how these different scenarios compare to various policy goals that the Commission has articulated.

First, we examined the extent to which rebased allotments improved the relationship between DSH allotments and measures related to hospital uncompensated care costs.

Second, we looked at the extent to which how reductions affected expansion and non-expansion states since at the September meeting some Commissioners suggested that reductions should be applied to states independent of their state coverage choices.

And, finally, because we know that DSH funding is an important source of revenue for many hospitals, we looked at the extent to which the policies phased in

changes in an orderly way in order to minimize disruption for those hospitals.

So this figure shows DSH allotments per uninsured individual relative to the national average, and you can see that the rebasing scenario helps improve the variation between DSH allotments and the number of uninsured individuals in a state. This is showing what it would look like by 2023, about four years into the rebasing. So under the status quo, only five states would have DSH allotments per uninsured individual within 10 percent of the national average, but under the rebased scenario, more than half of states would have allotments within that range by then. And we found similar results for the other rebasing factors, which makes sense, because one of the goals of rebasing is to improve the relationship between allotments and the rebasing factors.

So knowing that the rebasing scenarios are better than the status quo, the question then becomes which measure should be used to rebase allotments. And to answer this question, you may want to consider how the various rebasing measures compare to hospital uncompensated care costs.

So when we looked at uncompensated care costs reported on both Medicare cost reports and on DSH audits, we found that the number of uninsured individuals was most closely correlated with levels of uncompensated care in the state. Conversely, the measure of the number of Medicaid enrollees and uninsured individuals was least correlated with levels of uncompensated care.

However, it's important to note that no measure we looked at was perfectly correlated with the hospital uncompensated care costs, even after we did that wage adjustment. And so under any rebasing scenario, there will continue to be some variation between DSH allotments and total amount of uncompensated care in the state even after allotments are fully rebased.

So this table shows the effects of different rebasing scenarios on states that expanded Medicaid and those that did not.

Under all scenarios, the amount of reductions is the same, 57 percent reduction, but you can see that under the scenario of rebasing based on the number of uninsured individuals, it results in larger reductions for states that expanded Medicaid.

Conversely, if reductions are based on the number of Medicaid and uninsured individuals in a state, it would result in larger reductions for states that did not expand Medicaid.

Rebasing allotments based on the number of low-income individuals in a state results in a policy that is sort of in between those two alternatives.

Under all the rebasing scenarios, most states would have allotments that are within 10 percent of their rebased amount within 5 years based on the assumptions that we put in place. However, some states would still have allotments below the rebased amount after 10 years, again, because we assumed that the increases would be applied more gradually than the decreases.

The pace of rebasing that we observe is really a result of the different assumptions that go into our analysis, and so, if you'd like, we could make different assumptions to phase in rebasing more quickly or more slowly. However, I just want to point out that because the total amount of DSH funding is fixed, any policy that reduces DSH cuts for some states would result in larger cuts for other states. So there's definitely some

tradeoffs to consider.

Your materials include more information about the state and provider effects of each rebasing scenario. Again, although the total amount of reductions is the same under all scenarios, there are going to be different winners and losers among states, depending on which factors is used.

However, I do want to point out that there are two different ways that some states may be able to potentially minimize the effects of DSH reductions on providers in their states. First, some states may choose to pay for Medicaid shortfall by increasing other Medicaid payments outside of DSH, such as base payments or non-DISH supplemental payments. And, second, some states may choose to minimize the effects of DSH cuts in particular hospitals by targeting the remaining funds towards those hospitals.

In order to examine these different scenarios, we have provided some of the state-by-state data looking at what payments to providers would be if states did pay for Medicaid shortfall through regular Medicaid payment rates, and we also looked at the extent to which the reduced DSH allotments would be sufficient for states to make the same

amount of payments that they're making now to deemed DSH hospitals, which is that group that's required to receive DSH payments and serves a high share of Medicaid and low-income patients.

I won't get into the specifics of the state and provider effects now, but if you have questions, I'm happy to answer them.

So that concludes my presentation for today. I'll leave you with these three decision points that I mentioned at the beginning, but again, I look forward to your feedback so we can come back to you with a full package in December and make progress towards a recommendation in January.

Thanks.

VICE CHAIR LAMPKIN: Thanks, Rob. That was really great. It really moves us forward from our discussion at the last meeting.

Before we dive into our detailed discussion, I just want to remind us that this is just one piece of our DSH discussion. We have talked in the past about different approaches that states use to allocate the DSH dollars amongst hospitals within the states. We've also talked

about the connections of the DSH funding stream to other ways that Medicaid pays hospitals.

We are not done with DSH after the next couple of meetings because we are going to have some of these other questions that we will need to come back to, but the timing right now is such -- and we talked about this last meeting -- that we have an opportunity to really now, as we move into what looks like the reductions taking effect, try to provide some guidances about rationalizing the distribution across states, which are heavily, heavily influenced by this, the historical spending anomalies of the past and not really connected to the measures that they should be connected to. So just setting that stage, there are definitely other parts of DSH we'll be coming back to.

Then as we dive in, Rob has given us quite the task list here, and I would like to suggest that the measures that he's presented us with have some implicit connections to the goals and the tradeoffs between different goals. That may be useful for us to articulate that a little bit, see how much consensus we have around what we think the uncompensated care that we're most interested in targeting is, and that may give us some

direction or some ideas about the appropriate measure or measures or different additional information that we need, if we can even just narrow down the measures.

So is there anybody who would like to start off?

Fred, do you want to start us?

COMMISSIONER CERISE: Sure.

First, Rob, great work, as usual. You have really laid out, I think, a real thoughtful analysis and given us some good direction.

Just to weigh in on a couple of your earlier questions, the phase-in to 2028, I think that's a good idea, sort of gradually get into it. Using unspent DSH dollars first, I think is a good idea of setting some guardrails, so there's no wide shifts. I think the way you've outlined that makes a lot of sense.

To your three sort of scenarios, it sounded like basing it on the number of uninsured is the one that most closely reflected the uncompensated care by states.

The other thought I have about that option -- and you can correct me if this is not accurate, but states have a number of vehicles to address Medicaid shortfall with supplemental payments, so starting with base rates, and

then if you don't want to do it in base rates and if you want to rely on supplementals because you got flexibility and non-state match, you've got other options there. But you have fewer options when it comes to the uninsured side of the equation.

So if the concern is the shift in Medicaid shortfalls, states have a way to address that, whereas they don't have the same flexibility to address the uninsured problem which for me would be a reason to focus it more heavily on the uninsured rate, even though, admittedly, states do have a way to address that too by doing Medicaid expansion. But if we take the premise we're not going to do an expansion, non-expansion, go to that issue, and you just base it on the problem to be solved. Basing it on uninsured would seem to be the more even way to address the problem across states, getting away from history.

VICE CHAIR LAMPKIN: Thanks.

Bill and then Sheldon.

COMMISSIONER SCANLON: First, I'd go back to the earlier discussion we had about cost and the difference between volume and unit cost.

I am really glad that you made the adjustment for

the cost, the Medicare cost index. I think that should be a very prominent part of any recommendation because we have got so much in terms of federal law, which uses one number nationally, a poverty number, and for all kinds of different programs. The reality is that both for individuals and their incomes, there's big differences in cost of living, and so your circumstances, where you are in life relative to where you are with respect to the National Poverty Index is potentially very different.

And the same thing is true with respect to the delivery of care. Variation in cost is very significant, and we have a very convenient, thanks to Medicare, measure to use to try and sort of make the adjustment. So I really think we should stress that.

In terms of the measure that should be used, I feel like if you introduce Medicaid, you're trying to serve the dual purpose of both adjust for uncompensated care and adjust for the shortfall, and you know I have had concerns about the shortfall.

But at the same time, we're in a very interesting period here, which is not introducing Medicaid creates an incentive against expansion. I understand we're phasing

this in, but if you want to neutralize, make the incentives the same, I think you think about introducing Medicaid as a measure.

But I'm not sure you should weight the two the same, count each Medicaid-eligible and each uninsured, because the consequences in terms of the cost of delivering them services are different. So we might think about how do you weight it for how much of an issue it is for a hospital to have a Medicaid patient and the shortfall associated with it and hope we could measure a shortfall better and then what are the consequences for the hospital having sort of an uninsured patient.

The last thing about the measures, I saw you adjusted in the last one for the non-elderly and only talked about non-elderly low-income people. I think the same should be applied if you introduce Medicaid. If we're talking about Medicaid seniors -- I mean, essentially, it's for duals. That where Medicare is going to be the hospital payer and they should not be counted in this.

I understand the arguments -- and we may hear some of them -- about the issue should DSH be targeted only on hospital services. That's a different discussion we

could have.

CHAIR THOMPSON: Sheldon, then Penny.

COMMISSIONER RETCHIN: First, I'll ask a question and then come back to the issue I have regarding third-party involvement.

Rob, I personally advocate your approach on low-income individuals. I think it tracks kind of in principle the way we look at FMAP and the allocation of Medicaid and federal share. So that's attractive to me.

But could you take a state? And let me just offer Virginia. Many of the changes that the different allocation methods don't really make that much of a difference, and overall, it is very slight, remarkably slight. But then I look at a state, and maybe it just has to do with expansion and non-expansion. In Virginia, can you tell why does that make such a big difference?

MR. NELB: Let's see. Sure. In your materials, we have two different ways we looked at the state effects. One was the change in allotments, and another was sort of estimated change in DSH payments.

COMMISSIONER RETCHIN: Just do allotments.

MR. NELB: Got it. Yeah.

This includes both spent and unspent allotments, and so Virginia seems to be a case where they maybe don't spend their full allotments. What maybe looks like a big cut, when you're just looking at the allotments, may not be quite as big of a cut when you're looking at the amount that's spent on providers.

To get into a particular state, I'd have to double-check the different numbers. Of course, we used factors from 2016, and so Virginia is a new expansion state. Number of uninsured will change in the future and different things, so this is looking at sort of their pre-expansion state, where they were.

Yeah, it looks like they -- well, the status quo scenario is sort of its own piece, but as a non-expansion state, they had sort of more uninsured than average. So they were going to get an increase --

COMMISSIONER RETCHIN: Yeah.

MR. NELB: -- under our rebasing scenario, but when you counted Medicaid and uninsured as a non-expansion state, they got a decrease there. Under the low-income scenario, they were pretty much stable.

COMMISSIONER RETCHIN: So maybe in December, I'll

take back what I said and that maybe understanding a state or two would be useful, especially in the wide fluctuations.

Then just to make a point now in session, I've said this before. I do think I understand we can't solve DSH entirely, I guess, in perpetuity, but I still think that having third parties in states responsible for allocating supplemental payments doesn't -- it's linked back to the notion of provider taxes, which I as an individual was able to determine where my taxes go. I think that in terms of provider taxes, it doesn't, in principle, make sense to me.

VICE CHAIR LAMPKIN: Thanks, Sheldon.

Penny, then Alan.

CHAIR THOMPSON: So I had sort of similar sentiments I think to Sheldon.

I was a little struck by some of the state-by-state. When we look at the total universe and kind of where people are gravitating to, that's kind of one, an important element of analysis. The state-by-state numbers look quite striking in some cases.

What are your thoughts about how to -- is it

because of this -- like we need to dig in a little bit better and see where the state-by-state effects are, or is there a way to soften those effects so that they're not so dramatic? Can you just speak to if there needs to be an adjustment or there needs to be a recognition of other things in particular states?

MR. NELB: Sure. So there's two different differences, I think you see. One is the variation between the different factors, which it's like a non-expansion state will maybe do better under the uninsured and an expansion state will do better under the other factor.

The other piece, though, is where you see sort of big cuts for a state, even regardless of the scenarios, and this comes down to a state that spent a lot of DSH funds in 1992 and is sort of -- compared to other states is sort of much higher relative to any sort of average.

And to soften the effects on those states, you basically want to slow the pace of rebasing, and it could be done in a couple different ways. As it is now, we assume that the increases for the low-DSH states are happening at the same time as the decreases. You could kind of push off some of the increases for low-DSH states.

You could look at that upper bound on cuts. We assume that 30 percent, you could have a smaller amount. So we can look at some different ways and perhaps come back to you with a closer look at these are the states that are going to be most affected and maybe looking at whether we think they would potentially be able to offset the cuts by increasing other payments or whether they wouldn't. So we can take a look.

But, basically, those states with the really big cuts are ones that -- I mean, also even tend to get big cuts under the current methodology, but just because their allotments are so large. Yeah, that's correct.

CHAIR THOMPSON: I think that would be helpful.

And then the other thing that I would say is that I'm probably more in Sheldon's camp about which measure. I'd like it because it's neutral. I do understand the point of -- I've been concerned about Medicaid shortfall and about creating the wrong incentives. I do agree that states have levers for that, but also states have levers around coverage decisions.

I think when we focus only on the uninsured, I think by distributing reductions that were thought of as

applying across all states now to primarily affect states that made expansions, I think we kind of have the opposite effect of too much happening in expansion states versus non-expansion states.

I think low income is a good proxy, especially at the state level for DSH distribution. I think when we get into some of the other conversations that we might want to have later about how this relates to non-DSH supplementals, how this relates to distributions within the states, I think there's opportunities then to use some different levers to have some different kinds of conversation.

When we talk about rebasing across the states, I think looking at low income as a proxy for need and pressure on the state around its safety net system seems a reasonable place to go. The fact that it happens to have kind of middling effects in comparison to the other two options applies to my centrist, you know, inclinations, but it's more about taking it off of the plate of state options and decisions and going to something about the populations that are needing to be served.

VICE CHAIR LAMPKIN: Alan and then me.

[Laughter.]

COMMISSIONER WEIL: I'm going to end up pretty much where Penny did, so I'll try not to be repetitive.

It is striking to me, as important as this set of decisions is, that when you present to us the tally of the number of states affected in certain ways by the different policies, they are strikingly similar over at the aggregate. So I'm sitting here thinking we are looking at these very different choices, and we have to get it right. And we do.

But it's less calibrated than I had thought at the outset. I think this notion of looking at it sort of at the state level and realizing that whatever differences there are in these approaches, they're actually quite consistent in the number of states they affect in the size of their cuts overall is telling to me that we shouldn't try to over-engineer this.

I'm drawn to -- Stacey, I liked your trying to keep us to the goals at the beginning, and what I'm realizing in my own thinking and in my listening to my colleagues here is that the goal that we've stated of applying reductions to states, independent of state coverage choices, is not a simple goal to interpret because

there's the question of are you penalizing or not for a decision one way or another, or what are the incentives for making the decision. Are you changing the incentives for deciding one thing based on -- and so this, I think, is actually the crux of the matter, is that as much as it sounds good to say, "Oh, we don't want to get in the middle of," by definition, we are in the middle of. And there is no way for this choice to be completely independent of state and coverage goals.

So that's where I land, and I'll just say it slightly differently than Penny. But I think it will hopefully sound fairly similar.

We've talked a lot over the years about how many different lever states have on payment. So you have to look at this in the context of those other levers.

What is it that's unique about DSH? Two things. One is it, by federal design, is designed to support hospitals that have a disproportionate share of needy populations. So that makes it relevant but targeted.

But the other is it's now capped, and most of the other levers we talk about are not capped. Your payment rates, you can change your payment rate. There's no cap.

So I go to the notion that within state -- and I don't want to lose Sheldon's point. Within state, I think it's very important how the allocations are made within state, and maybe at some point, we're ready to take that. But before we take that on, across states this really should be tied to, if you will, a more objective standard of underlying need, not so much tied to the other policies.

From work I've done elsewhere, low income has some of the same cost adjustment problems. Below 100 percent of poverty is a very different share of people in New England, in Massachusetts, than it is in Alabama, but still moving more toward an income-based or poverty -- a number base that's consistent with how FMAP is calculated, and it avoids stepping on and changing the policy incentives associated with coverage or other payment rates. So that's where I would tend to go.

VICE CHAIR LAMPKIN: Thanks. I'm going to weigh in and then it'll be Darin, Kit, Martha, and I wanted to go back to the goals, too, and talk about that, because I agree with Alan. I think it's really tough to stay out of the coverage decision here in this dynamic.

I personally am more aligned with Fred's

preference, and the reason -- maybe I'm bringing different goals in than are on our slide, but for me the concept of transparency and rationality are coming into play here. And yes, I'm thinking ahead to kind of our other payment streams conversations. But it's strongly appealing to me to say we want to be able to know what we pay for Medicaid services, to Medicaid individuals, and the more places that you have to go to find those dollars and try to pull them into some kind of rational measure makes things really challenging.

Plus Fred's comment that states have other levers that they can use to rationalize or to make appropriate payment for Medicaid services leads me to favor the low-income -- I'm sorry -- the uninsured measure, with the low-income one being my second choice. I do understand the arguments for that, but I just really -- it appeals to me to think that uncompensated care here could focus not only Medicaid shortfall it's cleaner to have that dealt with somewhere else. So that's my own thought.

All right, Darin.

COMMISSIONER GORDON: Well, so I'm glad you went before me, because I think that was a good articulation of

where I'm at. I think the points that Fred made are good ones. I do think, to some degree -- and when we talk about some of the state variations too, we're also hindered by, you know, some of this is an artifact of the old model and so some of these changes are almost -- well, let me say it this way. We can't act as if that was the perfect state to begin with. And so some of those dynamics, we're going to see some big swings regardless because things are very different.

But for all the reasons Fred had stated, and Stacey, I'm more aligned in prioritizing uninsured. I do think, to some degree, you know, we don't have to necessarily say, when you think about the uninsured or if you think about Medicaid shortfall that it's an equal weighting on both. I mean, that's another option is to weight those differently. But I lean more on the uninsured side, thinking that that is the bolus of where I've seen DSH funding go in the past. It is a dynamic that doesn't go away, whether you expand it or you didn't. It's something that's going to have to be addressed. And then we can get into all sorts of other discussions, to Sheldon's point, about how, if you look at those formulas

within states and how those things are administered and driven that there's a whole other discussion there.

VICE CHAIR LAMPKIN: Thank you. Kit, then Martha, Toby, and Melanie.

COMMISSIONER GORTON: So first thank you, Rob, for once again -- and Madeline and everybody else -- for taking enormously complex stuff and making it somewhat understandable, even for simple-minded people like me.

One, so I would agree with what other people have said, either the uninsured one or the low-income one, and for me I'm not sure there's a clear first choice. I can make either argument. So whatever the sense of the Commission would be I think I would be comfortable with that. I do think that taking Medicaid shortfall out of it makes sense, for all the reasons that have been articulated and I won't repeat them here.

What I wanted to do was ask you, Rob, and Anne, maybe, to remind us, inform us, educate us, when we deliver this chapter how will the staff capture this sort of -- which have infinite possibilities, and then we're down at three options, and we ended up in this place, or do we just simply say -- and I apologize, I don't remember -- we think

you should do this?

So it would be helpful to me to understand how much of the background thinking about the choices we made, the options we considered, and where we finally landed, will we be sharing that with Congress and with the audiences so that if they decide they don't like our recommendation they at least have the benefit of the discussion.

EXECUTIVE DIRECTOR SCHWARTZ: Typically what we would do is there's a recommendation, which, as you've heard me say a number of times, is a specific thing that we're recommending a specific somebody do. In this case it would be a change in the statute; Congress change the statute to X. And then in the rationale you would say why we came to this decision and what other alternatives we considered and why we thought the one we chose was superior, for whatever reasons. And you can also say, in that part, that none of them is perfect. You can structure that rationale to help the decision-makers understand why you made the decision and what else we considered.

Also, just to remind you that the decision-makers are privy to all of this as we go along, in any case, and

how that factors into their ultimate decisions to do whatever is beyond our control.

VICE CHAIR LAMPKIN: Okay. Martha, then Toby, and Melanie.

COMMISSIONER CARTER: I'm going to go back to the point I made earlier, my worry about individuals who are insured but have high deductibles or somehow are going to wind up bad debt. I wish I had a crystal ball to see how all the changes are going to affect us. And, you know, we're handicapped working with old data. But at the primary care level we're certainly seeing an increase in bad debt, somewhat because of employer choices in the coverage plans that they can afford. So we've got people with high deductibles that wind up receiving care but then not being able to pay their bills.

And then with the approval of plans that don't conform to the ACA coverage requirements we're going to wind up with people who are insured but not covered in the same way that they have been, perhaps, in the past, coupled with, perhaps, people coming off Medicaid in states that implement work requirements. And so we've got this whole constellation of changes that could be coming that could --

and I think we're already seeing it at the primary care level, to some extent -- that could increase the bad debt rate for people who are insured but can't pay their bills.

So for that reason I'm just expressing the worry, I want to get it out there -- I'm a worrier -- but also I think that makes me come down on the option of low-income rather than tying it to a payment methodology.

VICE CHAIR LAMPKIN: Toby.

COMMISSIONER DOUGLAS: So I also recommend the methodology of low-income, and I start from aligning with the comments that others made on that definition but also the fundamental for me is that this is about one payment stream of many. So as we think through the structure, the allotments, it's really on a definition that doesn't get into policy choices around Medicaid expansion or not, because states that expanded weren't really thinking about -- they made their expansion decision putting aside payments in another lever. And so there's the allotments.

Then there's how states use it, and that gets into the definitional and the transparency of whether they're using it to cover uninsured, uncompensated. So really separating those two pieces but focusing on

allocations here, and then there gets to all the issues about how states structure and what's our definitions, given states use it differently now.

VICE CHAIR LAMPKIN: Melanie.

COMMISSIONER BELLA: Yeah. Thanks, Rob. A couple of comments and one question. So comment, just going to the timing. I just want to say I agree with Fred, which is in support of your recommendation of carrying it out to 2028, just because we haven't talked about that.

Second is I'd reiterate, I guess, what Toby and others have said. I, too, come down on the low-income individuals. As Sheldon and Penny have both said, I mean, it is very much in line with how we think about FMAP and I also like the fact that it's more balanced. And I guess I would say like put aside for expansion for a minute. There are other policy things we'll be talking about today, like work requirements, that will influence uninsured rates, and I think we just have to think about, we really don't want to have anything in this program that is incented or not, unintentionally. And so there are different things that can drive that in ways that low-income individuals cannot.

And so I guess my question is a couple of times

there was the reference to states have tools, and it was part of the rationale, I think, for supporting the number of uninsured. I don't understand what that is. If the tool is that the state can increase the base rate, I don't think we can rely on those kinds of tools. States don't have a lot of extra cash sitting around to increase the rates.

And so I'm just curious, what are the extra tools, either Fred or Dan, you were referring to?

COMMISSIONER GORDON: So, I mean, presumably, in some cases, I mean, granted, in some cases, DSH is supported by hospital taxes, but otherwise they are supported by general funding. And so if there is a reduction in your DSH portion of share payments that's one avenue which, if you were to deploy that funding, if you put it into your base rates you would still get the same match and be able to do it. And back to Stacey's point, which I really do like, gives a little bit more transparency to really what's going into hospital reimbursement. I mean, we have a lot of states that pay very, very low on the direct care rate and I do not like that disconnect between the direct services to individuals

that are eligible for the program that I think DSH sometimes distorts.

But again, if there's a reduction on total DSH allotment I have general funds that were supporting some of that, that I could now redirect through base rates, which I think is a better route to go.

COMMISSIONER DOUGLAS: But, Darin, wouldn't that deal with how states -- not the allocations but then the question about transparency on methodologies of --

COMMISSIONER GORDON: If you're doing it to a base rate -- I mean, there's transparency on several fronts here, transparency on what's being done through DSH and/or supplemental payments but also transparency of really what's actually being paid to a hospital for a Medicaid beneficiary that is somewhat distorted. If you look at direct reimbursement rates it's distorted by this kind of foggier place over here in DSH that is offsetting some of that. So because it's more clear if it's not in DSH the more you can move it into direct reimbursement of my base rates then everyone sees that much more clearly.

VICE CHAIR LAMPKIN: Thanks, everybody. This has really been a helpful conversation. Now when we go back to

the task that Rob put in front of us let's see if we can kind of pull the strings together and the thoughts together. I've been keeping a little bit of a running tally. Not everybody has weighed in but of those who have weighed in it sounds like there's a little bit of a preference for the low-income measure versus the uninsured, which is running, you know, a second place, but not a super close second place, with the third one left in the dust.

Okay. So I think the question for those of us, like me, who preferred the uninsured measure is can we get to low-income? If we can, do we need anything more from Rob to help us get there? Where do we feel about that? I'll start since I was one of the low-income people.

I think the main thing that I would like to understand, and this may be useful for the other shortfall concerned folks, is if we were to go to a measure like that and then down the road say we think shortfall can be handled elsewhere, does that produce any kind of disconnect with the way the dollars have been allotted and states' ability to spend them based on costs other than shortfall, or is that still going to look fairly rational? To me that would be useful but I could be in the low-income camp as a

neutral middle ground, assuming that didn't produce some unexpected distortion.

So are there others who were in a different camp who can weigh in? Darin and then Bill.

COMMISSIONER GORDON: Yeah. I still obviously prefer the uninsured route, where I was before. If you do low-income -- and I'd actually say this with regards to whatever path we end up on -- the thing that I struggle with, historically you make these decisions, you look at it once and you don't look at it again, and there's a lot of the dynamics that change. And I think DSH has been one of those that we looked at, at one point in time, and it hasn't changed for many, many years. If you are going to look at either of these measures some kind of regular occasion that you're relooking at that, because things change in these states, I think would be helpful.

COMMISSIONER SCANLON: I don't think I had a camp before, and I'm still not sure. But I think one thing I'd like to know about is what would be the consequences of using sort of low-income on the uninsured. Because the issue here is we're not changing FMAP. We're allocating a fixed pot of money. States have a lot of levers, but they

will use them independent, potentially, of sort of how they react to this amount of money. So there's going to be a consequence when you look at the low-income, states that have expanded have gotten an enhanced match to expand, so they're getting federal funds to help those people, and now they're going to get more by using low-income for DSH as opposed to what they would get with the uninsured.

And so I think the population that's still at risk are the uninsured -- at the greatest risk. Let's put it that way. And so I think knowing sort of how you change what the dollars are available for the uninsured, from making a choice between these two, would be an important thing to know.

VICE CHAIR LAMPKIN: Fred.

COMMISSIONER CERISE: I think that's a good point. Listen, I mean, there's no right answer to this. I think getting away from historical allocation is a good move. I mean, the DSH reductions were premised on the fact that the uninsured was going to go down.

CHAIR THOMPSON: Across all states.

COMMISSIONER CERISE: Right. But, I mean, you know, to go back to Alan's point, I think you can't

separate it from expansion and non-expansion. I mean, what I hear is a push towards to say we don't want to incentivize states or gives states any encouragement to not expand, is sort of what I hear if we folks on the uninsured, because the DSH reductions were premised on a reduction on uninsured so you wouldn't need the DSH funds because people were going to be on Medicaid.

And so I do think, still, the truest form of addressing it, and states do have more leverage to address Medicaid shortfalls, and you have your analysis that shows the uninsured -- the number of uninsured best correlates with hospital uncompensated care costs.

So for those reasons I think that one makes the most sense. I realize there's not a perfect answer here, and if the decision is to use a low-income metric, but I don't think that best assesses the uninsured left in those non-expansion states, those places, are going to have a greater need because they're not getting the additional Medicaid payments and they have fewer levers to address the uninsured.

VICE CHAIR LAMPKIN: Melanie.

COMMISSIONER BELLA: I just -- I don't think that

we can assume that states have unlimited levers, even if it relies on general fund dollars. And so I think that's just a little bit of a fallacy. Well, I know, but everyone is acting like with this one there's all these tools that states have, and that's a reason to do it a certain way. If they don't have the general fund dollars they don't have any tools. And so if there was money sitting around for them to increase rates they'd be dealing with access and capacity issues in other ways.

And so I just think -- I just think we shouldn't rely on that as if it's an obvious solution, because they do have limited funds.

COMMISSIONER CERISE: And I could just tell you in my state over half the hospital payments are not base payments. They're supplemental payments, and those are not coming from general funds.

COMMISSIONER BELLA: [Off microphone.]

COMMISSIONER CERISE: But they have options other than general funds.

CHAIR THOMPSON: And, right. And there's an interesting question about whether that gets hospitals in Texas more money than expansion would have.

COMMISSIONER CERISE: This is not a Texas, non-Texas.

CHAIR THOMPSON: Right. Right. It just makes the point that the question of whether uninsured is the thing that is given the ways in which different states structure. You know, the other thing that I would just point out is we just heard about the fact that we have -- although I know that, in theory, many of us are concerned about Medicaid shortfall as an element in this equation because of what Stacey mentioned, which is our preference is have adequate rates to pay for covered services delivered to eligible beneficiaries. The fact of the matter is that we're seeing that shortfall is having an effect.

And so I just, again, to emphasize the point about trying to go to a more of a neutral measure, the benefit of that being there are all these different, I won't call them levers. I'll call them factors, of what's happening in the state, what's traditionally happened in the state, how states have thought about expansion, how states have thought about payment rates, how states have thought about pools.

And so I kind of go back to something Alan said, which is, you know, do we really want to try to over-engineer this, especially if, you know, there's a lot of factors that are going to play into how states respond and what states have been doing. And again, I reiterate, that's why, in part, I think the more neutral population-based measure of need is superior in staying away from some of those impacts and effects and interactions.

VICE CHAIR LAMPKIN: Darin.

COMMISSIONER GORDON: Just on another point on the shortfall thing that I always struggle with is that is a component where -- and again, it could, depending on where you look at this, it could be in the formulation on how they actually distributed DSH or not -- but where hospital cost, which you don't control, and, quite frankly, that concerns, can have a stronger influence. And I'd like to diminish the weight that has in that formula, because I can't say that everyone approaches their development of cost the same way.

CHAIR THOMPSON: Right. I'm just saying that there's a lot of things I think we talked about as a Commission that we want to move things in this direction

versus that direction, and the question of whether this is the place to do it or to kind of step back and say, you know, let's find something that is objective, that we have a good data source on, that's neutral. We're not going to be able to manage all these interactions, state by state by state, in any kind of way that has any sensitivity towards all of these factors and goals. So let's stay high level.

You know, it looks like in the results we don't have a tremendous swing, although we will have a swing on individual states. And I do think coming back with a little bit more of some of these questions and analysis on this basis can be very helpful. But that's why I think it makes more sense to move in that direction.

VICE CHAIR LAMPKIN: Okay. Anything burning, because we've used our hour on this, and I think we've made -- it seems like we've made really good progress. We have a measure to move forward with, maybe a few assurances and extra pieces.

We heard a couple of comments on the timing of the phase-in but they were generally positive. So does anybody else need to weigh in on the phase-in approach that we've seen, or that it's good to keep running with those

concepts?

[No response.]

VICE CHAIR LAMPKIN: All right. Great. Thanks, everybody.

CHAIR THOMPSON: Okay. So why don't we see if there's any public comment that we want to take before we take a short break.

PUBLIC COMMENT

* MS. GONTSCHAROW: Hi. Good morning. Zina Gontscharow with America's Essential Hospitals, and we thank the Commission for the opportunity to provide comments today and for the Commission and its staff for its thoughtful work on Medicaid DSH payments.

As the Commission considers recommendations to Congress, America's Essential Hospitals urges the Commission to clearly communicate the impacts that the impending DSH reductions will have on hospitals in communities across the country. The magnitude of these cuts cannot be overstated, especially with the steep cliff of the reduction schedule where two-thirds of the funding will be wiped out within two years. This is a crucial funding stream and it will be effectively gutted, a funding

stream that currently does not cover all uncompensated care costs shouldered by essential hospitals, as confirmed by the latest analysis even post-Medicaid expansion. This will have a great impact on patients and the essential hospitals that care for those patients. This must be made clear to Congress and policymakers.

Further, the association urges the Commission to provide recommendations around the better targeting of the DSH funds to hospitals with high levels of uncompensated care that also provide access to essential community services. Targeting the hospitals within a state is just as important as allocating the ACA-mandated DSH reductions amongst the states. Targeting will be especially important if the reductions to Medicaid DSH are fully implemented as scheduled. They cannot be separated.

Thoughtful targeting is key to ensure that mission-driven hospitals that currently serve a vital role to their respective communities are supported. These are hospitals that are committed to caring for the most vulnerable, training the next generation of health care leaders, providing comprehensive coordinated care, providing specialized life-saving services, and advancing

public health.

America's Essential Hospitals appreciate the opportunity to submit these comments and we look forward to collaborating with the Commission as it continues its important work on this issue.

Thank you.

CHAIR THOMPSON: Thank you for those very thoughtful comments. Any other public comments at this time?

[No response.]

CHAIR THOMPSON: All right. We'll adjourn and be back at 11:15.

* [Recess.]

CHAIR THOMPSON: Okay. If we can get started on the last session for this morning.

Okay. We're here to follow up on the conversation that we began really in earnest at the last meeting on working and community engagement requirements, focusing on what's happening in Arkansas since that's our live demonstration at the moment. So, Kacey, you have a presentation that responds to, you know, a lot of the questions that the Commissioners were asking at our last

session. We're going to let you go through that, and then we're going to kick off Commissioner conversation in response.

UPDATE ON IMPLEMENTATION OF WORK AND COMMUNITY ENGAGEMENT REQUIREMENTS IN ARKANSAS

* MS. BUDERI: Great. Okay. So today we'll continue our discussion of Medicaid work and community engagement requirements focusing on Arkansas, which is the only state with requirements currently in effect. And as you said, Penny, at the September meeting Commissioners expressed concern about initial data showing that 4,300 people had lost coverage following noncompliance in the month of August. And the Commission had a number of questions about the state's approach to implementation and some of the challenges with it.

So today I'll be providing you with some additional information on the areas you flagged, and this presentation draws from publicly available sources and conversations we've had with people in Arkansas who include staff from the Arkansas Department of Human Services; the Arkansas Foundation for Medical Care, which is the state's beneficiary relations contractor; Arkansas Blue Cross Blue

Shield; and Arkansas Advocates for Children and Families; and then we've also spoken with CMS, the Centers for Medicare & Medicaid Services.

I'm also going to talk about some of the data that Arkansas released in its latest monthly compliance report which shows an additional 4,100 people were disenrolled for noncompliance in September.

So I'll start by providing some background on Arkansas' work requirement policy. I'll discuss the compliance data for the first four months of the program and some of the implications. And then I'll talk about some of the outreach and education strategies the state and its partners are engaged in, challenges that remain for beneficiaries with regard to reporting, and efforts being made to connect beneficiaries with supportive resources. I'll also talk about oversight requirements, including monitoring and evaluation and CMS' role, and I'll conclude by describing some next steps which, as we discussed at the September meeting, could include a letter to CMS.

So as a refresher, requirements in Arkansas currently apply to members of the new adult group age 30 to 49 with incomes below 100 percent of the federal poverty

level. Next year, Arkansas will begin phasing in the requirements to beneficiaries age 19 to 29. Individuals subject to requirements must either qualify for an exemption or report work activities. Some of the exemptions are automatic, meaning the state can identify them with administrative data and action is not required by the beneficiary. Individuals without an automatic exemption need to report information each month through an online portal. They can either report an exemption not previously identified by the state, or they can report at least 80 hours of work or qualifying activities. Beneficiaries who fail to meet these requirements are disenrolled after three months of noncompliance in the calendar year, and then they are locked out of the coverage for the remainder of the year. They cannot re-enroll unless they qualify for another Medicaid eligibility pathway or receive a good cause exemption, which is a retroactive exemption intended for people who experience some type of temporary hardship.

Okay. So though it's not required to do so by the special terms and conditions of the waiver, Arkansas is releasing monthly reports with information on compliance.

You saw a version of this figure at the September meeting, and it now includes the latest information which was released last week. And as you can see here, we have data for June through September. The state phased in enrollees in groups, which is why you're seeing an increasing number of individuals subject to the requirements.

Across all four months, they show that most beneficiaries had an automatic exemption, which is the green part of those bars, and then of those who did not, most were noncompliant, who are the light blue portion of those bars.

So the Commissioners had a number of questions about this data at the last meeting, and I'm going to discuss it in greater detail in the coming slides. I'm going to primarily refer to September data because it's the most recent and it includes the most enrollees. In general, all proportions held across the four months, but I'll note any changes.

Since September, about three-quarters of beneficiaries subject to the requirement had an exemption. Ninety-six percent of those exemptions were automatic, meaning that beneficiaries did not need to report anything

through the portal. The remaining 4 percent were reported through the portal.

The most common exemption was having income consistent with working 80 hours or more per month at Arkansas minimum wage, and about half or 46 percent of exempt enrollees were in this group. Exempt enrollees. The other half was primarily made up of people who were exempt from SNAP work requirements, who were determined medically frail, or had a dependent child, with a small number falling into other exemption categories.

In our conversations with people in Arkansas, some noted that the exemption policies were a source of confusion for beneficiaries. For example, beneficiaries might see a list of exemptions and not realize that they need to go in and report that exemption. And, also, the exemptions are valid for different lengths of time, meaning that people might not realize when they need to go back into the portal and update that exemption.

And so for the beneficiaries who were not exempt, which was about a quarter of beneficiaries in September, 8 percent complied with the requirements. Of these, two-thirds were identified as compliant through SNAP work

requirements. They were identified as compliant with SNAP work requirements through a data match, so they did not actually report anything through the portal.

The remainder did report through the portal, and the most commonly reported activity was work, either alone or in combination with another activity, but DHS does not track through the portal whether these work activities are associated with new or existing employment.

Of those who were noncompliant, which was about 91 percent of beneficiaries without exemptions, 99 percent were noncompliant because they reported no work activities through the portal, and the remaining 1 percent reported fewer than 80 hours of activities.

According to DHS, they do have data on beneficiaries who start the process of creating an account but don't enter information, and they share this with AFMC, Arkansas Foundation for Medical Care, but neither DHS nor AFMC described a systematic process for using that information, and they didn't share the data with MACPAC.

So as of October 8th, 8,462 individuals had been noncompliant for three months and were disenrolled, and this total represents about 19 percent of beneficiaries who

have been subject to the requirement for three months or more or 62 percent of those without an exemption. An additional 12,580 beneficiaries are currently at risk for disenrollment in future months because they have been noncompliant for one or two months.

So Commissioners were interested in how these coverage loss figures compared to other disenrollment reasons. So looking at reasons for disenrollment from Arkansas Works, which, as a reminder, is Arkansas's expansion program, noncompliance with the work requirement was the most common reason for disenrollment in September and the second most common in August, making up 27 and 24 percent of Arkansas Works disenrollments respectively.

I'll note that the comparison here gets a little bit tricky because not all Arkansas Works beneficiaries could be disenrolled for noncompliance with the work requirements in those months, only people who had been subject to the requirement for at least three months could; whereas, all Arkansas Works beneficiaries could be disenrolled for other reasons.

The disenrollment rates are comparable or higher than disenrollment rates in states with waiver policies

that require premiums as a condition of eligibility. For example, as I mentioned, about 19 percent of beneficiaries subject to the requirements for three months were disenrolled for noncompliance, and this is about equal to the 18 percent of Indiana Medicaid expansion enrollees who were required to pay premiums and were disenrolled for nonpayment in 2017. However, other states with similar policies, including Montana and Iowa, had much lower rates of disenrollment.

So you asked at the September meeting about some of the implications of disenrollment. When beneficiaries are disenrolled, they receive a notice that contains information on how to apply for a good cause exemption, the circumstances under which they may be able to qualify for Medicaid through a different pathway or advance premium tax credits, and where to access free or low-cost health services. However, the state is not currently analyzing whether beneficiaries gain other sources of coverage or what kinds, or whether people are accessing care through the sources noted in the disenrollment notice.

The state is tracking beneficiaries who apply for and receive good cause exemptions, and the number that

applied was very low at first. It was none in June, four in July, and then that grew in August, reaching 246 in September, and the state has been granting the majority of those requests.

The characteristics of disenrolled beneficiaries, for example, their health status, those are unknown because the state is not currently analyzing data on this, and we also didn't hear any anecdotal reports on this.

The state is not currently collecting data on any downstream effects of coverage losses, for example, effects on the safety net, uncompensated care, or health plan risk pools.

So to better understand some of the factors leading to low rates of compliance and the high disenrollment numbers, Commissioners wanted to learn more about the outreach and education activities being conducted by the state and its partners. So DHS leads an outreach and education strategy. They send formal notices to beneficiaries through postal and electronic mail at various stages of the process. DHS has also made resources available in print, such as flyers and postcards, and online, such as instructional videos. However, most direct

outreach to beneficiaries is conducted by AFMC and the exchange plans. And so AFMC makes outgoing calls to new and existing beneficiaries who are scheduled to begin compliance in the following month, and they have a quota for the share of beneficiaries that is expected to reach and speak with. It also operates a call center where it gets incoming calls.

Exchange plans have no formal outreach obligations, but they are doing things like making calls, sending text messages and emails, distributing educational materials. They have been working on training their call agents to assist beneficiaries with understanding the requirements.

DHS and exchange plans have also done outreach work with providers, beneficiary advocates, and other stakeholder groups to help prepare them to help beneficiaries with the requirements.

Despite these efforts, however, there was a general consensus that beneficiary awareness of the requirements is low, and this is consistent with what other researchers have found. The people we spoke to cited a number of different contributors to low awareness, which

are listed on this slide. For example, the program is new, and the implementation timeline was tight. It was less than three months from approval to the go-live date. And while some of the preparations for implementation had begun prior to the waiver approval, none of the beneficiary outreach was happening until after the waiver was approved.

Also, the population is difficult to reach. AFMC and DHS were able to provide us with some data on this which showed that AFMC was able to reach about 23 percent of the target group of beneficiaries in each month for the first three months. The most common reasons for not being able to reach beneficiaries were not having a phone number available or having a bad number. The share of beneficiaries they could reach went up in September and October to about 50 percent, and this was likely because they switched from contacting existing and new enrollees to only contacting new enrollees whose constant information is newer and more reliable.

The exchange plan premium assistance program was also cited. Many beneficiaries were auto-enrolled in Medicaid and then auto-assigned to plans like Blue Cross Blue Shield or Ambetter, and some of the people we spoke to

noted that they just don't have experience taking action regarding their health coverage. And then several people also noted that they might not even know they have Medicaid coverage.

Some of the beneficiary advocates also said that, despite the efforts being made, the outreach materials themselves and educational materials were not actually designed well with this population in mind. The notices and instructions going out to beneficiaries, they noted, were long and overly technical. Many of the resources, like the instructional videos, are available online, and so they're out of reach to many people in Arkansas. And the language, they also noted, lacked attention to some of the known issues like beneficiaries not knowing they have Medicaid.

So besides low awareness, another factor that has been talked about as a contributor to low compliance has been the portal itself and the challenges that it creates for beneficiaries. So as a reminder, the portal is the only way beneficiaries can report compliance information. Normally states are required to allow beneficiaries to submit information related to eligibility through multiple

different means, but CMS waived this requirement for Arkansas. This approach does minimize state resources, but it has some characteristics that make it difficult to use on the beneficiary side.

Notably, it require Internet access, which is a challenge in Arkansas, which has one of the lowest rates of Internet access in the country. Setting up an account requires a reference number mailed to the address on file, though beneficiaries can request it through the AFMC call center. Set-up also needs to be done on a computer, although subsequent reporting can be done on a mobile device. The portal is only open for reporting from 7:00 a.m. to 9:00 p.m. daily, and media and anecdotal reports have also indicated that it is regularly down for maintenance on weekends. There was also a major system outage in September right before the deadline for reporting. Some of the people we spoke to also called the portal slow, difficult to navigate, and not visually appealing.

Arkansas has put in some resources to help beneficiaries overcome these challenges. Beneficiaries can call or receive in-person assistance from the county

eligibility office, who can walk them through the reporting process. They can also call into the AFMC call center where agents can answer questions about the process. AFMC can also make warm hand-offs to the county eligibility office or to the health plan.

Arkansas also set up a registered reporter process which allows a designated individual to report on behalf of an enrollee, and registered reporters are typically health plan staff, but other types of registered reporters include church and community leaders, family members, and friends. There were about 250 registered reporters as of September.

It's unclear whether beneficiaries are using these resources because help provided by county staff is not currently being tracked and neither is the number of people who had their compliance information reported by a registered reporter.

So going on to discuss work supports and other resources, CMS has specified that Medicaid funds cannot be used to actually provide these services to beneficiaries. However, Arkansas has done some work to connect beneficiaries with those offered through other programs or

organizations.

One of the things that DHS does is make automatic referrals to the Department of Workforce Services at eligibility determination and renewal, and they have been actually doing this since 2016, so prior to the work requirement.

Once this referral is made, DWS sends a follow-up letter to the beneficiary describing its services and how to take advantage of them, and the beneficiary can decide whether to take advantage of the services offered. AFMC can also do warm transfers to DWS if a beneficiary indicates interest in these services.

Through a data-sharing agreement with DWS, DHS has data on whether beneficiaries access services or gain new employment. However, the only data on this that's publicly available is from prior to the work requirement taking effect, and we've asked DHS for newer data, but they weren't able to provide it to us.

The degree to which jobs are available also has been cited as a concern in Arkansas and other states proposing Medicaid work requirements. And in Arkansas, it varies by geographic area, so Arkansas has five counties

that have been designated as labor surplus areas, although its overall unemployment rate is lower than the U.S. as a whole.

Arkansas beneficiaries also face barriers to work, and, in particular, these are those related to transportation or child care needs and lack of Internet access. And DHS publishes information online about where to access resources to address these and other barriers, but does not make referrals to organizations providing these services and neither does AFMC. The resources themselves are limited in rural areas of the state, and DHS is not currently collecting data on beneficiary need for, access to, or use of these services.

So now I'm going to shift towards talking about oversight of the demonstration.

As a Section 1115 demonstration, Arkansas' waiver program, including its work and community engagement program, is subject to evaluation and ongoing monitoring. So the STCs require formal independent evaluation to measure the hypothesis that work requirements will increase health and well-being, the effects of the requirement on beneficiaries' ability to obtain employment, and the degree

to which individuals can transition to other sources of health coverage and how this transition affects health.

An interim evaluation is due to CMS December 2020, but it's not clear when that will be made publicly available. At this point, Arkansas has submitted a draft evaluation design to CMS, but it has not been approved or made publicly available. And Arkansas is actually still in the process of procuring an evaluator, so it's unclear what kind of baseline data is being collected, what specific methods will be used, or what specifically will be examined.

In addition to this evaluation, which we don't expect for a fair amount of time, Arkansas does submit quarterly monitoring reports that provide updates on implementation and ongoing operations. They include compliance and disenrollment data as well as information on state outreach activities. However, they do not include information looking at transitions to work or other sources of health coverage, measures of health or access, or use of DWS or other supportive resources.

CMS and DHS also have regular monitoring calls where they go over data, report findings, ask questions,

and discuss concerns.

So the STCs, the special terms and conditions, of Arkansas' waiver do not include any triggers or specific language about the circumstances under which CMS might intervene in the demonstration. However, CMS can suspend or terminate demonstrations at any time.

There are a few instances where CMS has taken action in response to concerns about beneficiary harm. One example, CMS twice delayed approval of Iowa's managed care transition, citing concerns about network adequacy, possible disruptions in care, and feedback from beneficiaries and stakeholders about the state's communication strategy.

So, to wrap it up, I will note again that Arkansas is the only state with these requirements currently in effect, although two others, Indiana and New Hampshire, are approved to go ahead with implementation next year.

And you can see here on this slide where some of the differences are, which include a longer implementation timeline, multiple means of reporting, and lack of a lock-out period.

And in terms of other similar requirements and demonstrations coming down the pipeline, 10 other states have formally submitted applications to CMS. They include Alabama, Arizona, Kansas, Michigan, Mississippi, Maine, Ohio, South Dakota, Wisconsin, and Utah.

Kentucky's waiver, which was initially approved but then vacated by a court ruling, is also at CMS for consideration right now.

Then in addition to those states, several other states are at different stages of considering applying for these requirements, but they haven't actually submitted a formal request to CMS. For example, I know Oklahoma, Idaho, and South Carolina have all talked about this. There are others as well, and then I believe Virginia just closed their state public comment period.

So, as we discussed at the September meeting, our next step could be to draft a letter to CMS expressing the Commission's concerns about the coverage losses in Arkansas and any other areas the Commission wishes to highlight, and staff will continue to monitor Arkansas' and other states' implementation progress and any new reporting comes out.

And I will stop there and turn it back over to

you guys.

CHAIR THOMPSON: All right. Thank you, Kacey.

Just to let members of the public know how we're going to go about this conversation, we're going to have a discussion among the Commissioners. We will open it up for public comment, and then we'll come back to conclude our Commissioner conversation. So you guys will have an opportunity to engage with us in the middle of this.

I'm going to kick us off, and then we're going to go to Alan, Chuck, and then Darin to get this conversation going, and then we'll see if others want to weigh in as well.

First of all, thank you, Kacey. I know we gave you -- we had a barrage of questions that we had, and you did great in trying to go out and collect the information that you were able to collect.

I'd say I have a dozen comments or questions of a technical nature on some of the information that you collected, but that's not how I want to use my time because I don't think actually the answers to any of those questions affect kind of where I land on this at this point.

I am less interested in -- it's very unusual for this Commission to have a conversation about a single state implementation and to interject itself in what's happening in a single state.

Now, it happens that we're doing that in this case because Arkansas happens to have been the state that went live first on a topic of considerable interest, and I think that while there are strong feelings about work requirements, pro and con, both people who support them and people who don't support them would agree it's a significant program feature and change. So, of course, we're interested in the first-out-of-the-gate state.

Any state that went first out of the gate was going to experience some special scrutiny and some special challenges, so I think there's some things, as I look at this, that I think Arkansas has done a good job at, some other things that may be inherent challenges within this process in and of itself, some things they maybe could have done differently.

What I'm more interested in is having the Commission weigh in on how do we think about this in terms of lessons and applications to the group of other states

that are moving in the wake of Arkansas as well as Arkansas itself.

I want to just tether my comments to something that the Commission has spoken about before, which is our ability to harvest lessons and insights from 1115 waivers in a way that's timely and transparent and useful in a practical way to other people contemplating some of those same kinds of program features and design options.

In this case, we have a number of states who will be moving again to implement a very new program feature and approach in a very short amount of time, and this is not something that we've been great at, even when we had time and even when there was a long evolution of thinking. I'm reminded, for example, of managed long-term services and supports, where you had some states coming in to move populations into MLTSS. There would be experiences and implementation issues, and then the federal government for the next state would add some more special terms and conditions. Then that state would have certain kinds of experiences and challenges, and then the next state would come in -- I mean, it wasn't quite this linear, but the next state would come in, and there would be more special

terms and conditions because there would be new challenges and lessons learned.

That had its advantages and disadvantages. The advantage was that there was some learning over time, some changes in federal policy, some strengthening of beneficiary protections. On the other hand, states would complain that every time they came in to do one of these, there was kind of a new set of rules from the federal government about what the requirements were.

In this case, we have potentially a much more truncated -- depending on what happens with this other group of 10 states that are coming along, potentially a much more truncated amount of time from which to harvest lessons, understand what works, understand what states should be thinking about, understand how to evaluate in an early way whether these waivers are achieving their desired results or not. And it's that subject that I would like the Commission to weigh in on and potentially talk to CMS in a letter and maybe with an issue brief around what are the things that ought to be thought about here and how do you create a rubric or a framework for a conversation around what we expect to see happen in terms of process and

results, how do we start getting information as early as possible about impacts, what are the kinds of indicators or measures that would suggest that things are going well or we have a problem.

And I think it's the absence of some of that early framework and rubric, appreciating that we want to see an evaluation, but it's going to take some time for an evaluation to produce results.

How do we engage in kind of a rapid cycle feedback mechanism to really understand what's going on in these states as they do implementations and what kinds of things they need to be collecting data on, reporting on, what are the measures that would suggest we ought to have concerns?

I think in this case, we have places where we would like to have information and we don't. We have certain information that may suggest certain conclusions, but those may not be shared by everyone interpreting that same data. And so then I think it becomes very difficult to have a really focused conversation around what do we think about what's happening in this particular state or that particular state or how important do we think it is

for the federal government to have a special term and condition relating to this aspect of the demonstration versus that aspect of the demonstration.

And I think in this circumstance, where we're talking about a very significant program feature and change, a very substantial number of states that are interested in pursuing that in a limited period of time, the stakes are very high, and there needs to be a very close scrutiny and agreement around what is the framework for monitoring and assessing progress and results. And that's kind of where I'd like to see the Commission focus its attention.

So let me stop there and turn to Alan and then Chuck and Darin.

COMMISSIONER WEIL: Thank you, Penny.

I will try to be concise, but I can't promise I'll be brief.

There are those who believe that the social contract requires people to work or otherwise be engaged in order to deserve medical assistance. That, however, is not embodied in the Medicaid statute as an eligibility criterion, and so we move into the realm of research and

demonstration to test a hypothesis.

A hypothesis, as I understand it loosely, is that withholding Medicaid coverage will motivate people who would otherwise be disconnected from work and other activities to become engaged.

I've spent my career in health and social policy, and there's not any evidence that I'm aware of to support the hypothesis. So this is an opportunity to generate the data and evidence that enable us to test that hypothesis.

Over the life of Medicaid and welfare, which I have also studied, there have been a lot of experiments, and they've covered a lot of topics, including things that potentially could harm people who are the intended recipients of those programs.

As Kacey notes, the rates of disenrollment that we're seeing here are higher than, for example, charging premiums or other things that have potentially restricted people's access to care, and so that immediately sends up some caution that suggests the stakes here are unusually high.

As a Commissioner, I'm focused -- I think, Penny as you, but I'm going to end in a somewhat different place

-- on the question of what do we learn, and here's what I'm hearing from the materials given and, Kacey, your presentation. Acknowledging that a lot of the transparency is voluntary on the part of the state -- and I don't want to beat them up for telling us things and then us using them against them, but this is what I hear.

I don't see a robust research plan that will answer the question of whether or not the hypothesis is true. I don't see any efforts to randomize. This could have been rolled out by region. To my knowledge, they're not collecting data on the age groups that have not been brought in, which could give you a phased-in implementation that would give you some comparison groups.

What you're telling us about the status of the state-based evaluation and the limited information available about the federal evaluation does not give me much confidence that we're actually going to be able to determine whether or not the hypothesis is true.

I don't see new investment in the work supports that are needed. A referral is something that from the welfare evidence is not in and of itself likely to be effective.

From what I gather, there's very limited data collection regarding the actual people, and this isn't that many people. We don't know what they're engaging in. We don't know if their work efforts are new or their work with the workforce services is new. We, to my knowledge, are not asking any questions about their well-being, their income. These are all things, I should just say, that are part of the long series of research that was conducted prior to welfare reform, for example, literature I'm quite familiar with.

There are lots of operational issues that are being raised, and as someone who used to run a Medicaid agency, I respect the challenges associated with the change we're making. But one of the principles of administration is to try to have the burden of operational challenges not fall on the most vulnerable beneficiaries, but instead be something you try to work through behind the scenes. I do get the sense that time may make some of these better.

I am particularly concerned by the ratio of people potentially harmed to those who are potentially helped. So when I see very small numbers of people exempt through the portal, but then very high rates of good-cause

exemptions when they're applied for, that suggests to me that these terms of "compliant" and "noncompliant" are fiction. That the reality on the ground does not match the administrative data that we are collecting, and that to me is a big red flag for whether or not we're actually asking the right question.

I completely respect the notion that change is disruptive, and I agree -- I would use the same example, Penny, as you did, with respect to moving complex populations to managed care. Some level of disruption is inevitable. Some people will likely be worse off in the change. There's got to be some prior that you have about the balance of disruption or the ratio of disruption to the people who will benefit.

So what I am seeing in addition to a lot of people losing coverage is I'm not seeing evidence that will answer the question of whether or not the hypothesis is true, and that actually concerns me greatly. So I go back to our statute. I guess that's what you do when you're a lawyer. We are to review and assess Medicaid and CHIP eligibility policies, including a determination to the degree to which federal and state policies provide health

care coverage to needy populations. I don't think anyone is questioning whether or not the population affected by this is needy.

So the question is, what do we do about this? I don't have the answer. I talked to some people in the audience. I am looking forward to audience comment.

This is what I would say. At this point, I think it is appropriate to say that no additional state should initiate this policy -- and I realize that that's a loose term -- absent one of two things, either some promising data, which I am not yet seeing out of what's happening in Arkansas, or a much more robust research protocol than is in place here.

And I'm going to differ, Penny, with you with respect to rapid cycle improvement. To me, rapid cycle improvement is about improving operations. It's about making the program work. I'm more concerned that the fundamental hypothesis that underlies the experiment is not -- we're not going to have data to know whether or not it's true, and so I don't -- making something work better, if the premise on which it's built is flawed is better than not making it work better, but to me, those are somewhat

different issues, and so I don't want to just treat this as an operational problem.

I think the harder question is, what's the message to the Secretary, and what's the message to the state? I guess I want to withhold judgment, hearing from colleagues, but at this point, it's very difficult for me as a member of this group, with the charge that we have, to simply say, "We're going to wait. We're going to see how many more people lose coverage. We're going to wait for a few years to find out whether or not who of them did better and who did worse," and that some pulling of the alarm is essential. The nature of that, I'm going to withhold on, but the notion of saying we're going to stay out of it because it's one state, that does not feel appropriate to me at this point.

CHAIR THOMPSON: Thank you, Alan.

I did not mean on rapid cycle feedback that it was only operational, so I do think that it is about getting some sense of what's happening to individuals and, again, in support of developing that baseline and intermediate evaluative points that can give us a sense about whether we're more likely than not to be seeing

ourselves as achieving our objectives.

But thank you for that point as well.

All right. Chuck.

COMMISSIONER MILLIGAN: I will try to be concise, and I don't promise I'll be brief.

[Laughter.]

CHAIR THOMPSON: That is going to be the line all of us are going to use for the rest of our lives.

COMMISSIONER MILLIGAN: I always like stealing Alan's stuff.

[Laughter.]

COMMISSIONER MILLIGAN: So I had a couple of questions actually, Kacey, and then I will have some comments.

One of my questions is -- if you don't mind going to Slide 9? Yep, this one. I think this one.

So the bottom part of the slide, you mention 12,000 beneficiaries at risk, 4,841 with two months of noncompliance, so they might have a third month of noncompliance, 7,748 with one month. Do these individuals who are one month or two month noncompliant, do they get a notice of any type at the time?

MS. BUDERI: They do get a notice from -- a formal notice from DHS mailed to their home postal or, if on file, an email address.

COMMISSIONER MILLIGAN: Okay. And does that notice include the information around good-cause exemptions or how to apply for good-cause exemptions? What is contained in that notice that would prompt them, if anything, to have evidence of a good cause exemption and all of that kind of stuff?

MS. BUDERI: It's my understanding that information on applying for a good cause exemption is only included in the disenrollment notice, after you've already been disenrolled.

COMMISSIONER MILLIGAN: So if they're one month into three months of being noncompliant, or two months into three months, they don't get notice of how to pursue a good cause exemption before that disenrollment notice happens?

MS. BUDERI: That's my understanding.

COMMISSIONER MILLIGAN: There was one other question that I had, and then I'll kind of go into a few things. When you talked about the portal you said that they are mailed some kind of code about how to create an

account. Do we know how many of the addresses the states are using are bad addresses? Do we know how much -- you talked about low awareness, low information by a lot of the beneficiaries, that they're not -- that all of the people you interviewed generally said that there's a low level of awareness by the beneficiaries. Do we know how much the mail gets through to these folks, how good the addresses are? Do we know that?

MS. BUDERI: I haven't seen any data on how good the addresses are. The only thing I've seen kind of on that line is how many phone calls went through, like how many phone numbers were good.

COMMISSIONER MILLIGAN: So it's the phone outreach, but it's the mail outreach in terms of the portal access that they need.

MS. BUDERI: Right.

COMMISSIONER MILLIGAN: Okay. So I want to start, in terms of just comments, in a somewhat separate place. If we can look at Slide 5, if you don't mind -- I promise we won't keep bouncing around with slides. One of my thoughts about this is when I did the math it looks like 77 percent of the people are not considered noncompliant.

We've got -- so, I'm sorry. Slide 5 has the bar chart? Okay. Thank you.

So 52,000 people, the state identified an exemption; 2,200-and-something people reported an exemption; 1,500-and-something people complied with the work requirement. So I did the math. That's 77 percent of this group, their coverage is intact. And then the 16,757 are at risk. That's what this looks like to me.

MS. BUDERI: That's correct.

COMMISSIONER MILLIGAN: Okay. So I guess I want to say two things, high-level policy. One is I do want to acknowledge that Arkansas is publishing data, which they didn't have to do, and so I want to commend Arkansas for doing that.

The second kind of just broad-level comment I want to make is there are a lot of states that might not do the Medicaid expansion but for politically doing some kind of work requirements, and so I do think -- and I will have some comments about where I think there needs to be some process improvements, at a broader national waiver discussion level and less about Arkansas. But I do think that I don't want to lose sight of the fact that 56,509

people are getting coverage who might not get coverage if a state was required, politically or otherwise, to link a work requirement in order to do a Medicaid expansion.

I know we had a little bit of this conversation in September and it's not quite 1-to-1, the way I'm saying it. I want to be careful that it's not a 1-to-1 correlation between states that do work requirement and as a condition of doing a Medicaid expansion. But I know that in a lot of states they wouldn't do the Medicaid expansion if they couldn't do some version of a waiver like this, and to the extent that those dynamics were in play in Arkansas there are 56,509 people getting coverage who might not if the state had to do a work requirement, politically, to pursue this kind of Medicaid expansion.

So I guess I want to partly see the glass as half full here, just contextually. To me, in terms of the national discussion about work requirements and community engagement and waivers, my concerns about what your data show here is that I think whenever a state rolls something like this out the beneficiaries need to have an opportunity to know about it, to comply with it, and to succeed within whatever the rules are the state establishes. I think the

beneficiaries have to have that opportunity to know, comply, succeed.

And, to me, my concerns are in some ways less about the policy and more about the procedure piece of this, because, to me, the good cause notices, how to apply for a good cause exemption, let me put it that way, they come too late in the process if they're coming with the disenrollment, and I think that that, as a procedure, is too late to allow beneficiaries to, within their rights, avail themselves of that good cause exemption. So that's one procedural piece that I think doesn't give the beneficiary an opportunity to succeed within the rules the state is establishing.

To me the second part of that is, I think that there needs to be enough emphasis on member awareness, member education, beneficiary notices. I think there needs to be a stronger educational campaign piece of this if states are pursuing these kinds of waivers, to raise that awareness level to bring beneficiaries into knowledge. And one of the comments you made when you did your presentation was a lot of these folks aren't really accustomed to kind of how to -- they're not getting notices, they were auto-

enrolled in certain products, all of that kind of stuff. So I think the awareness piece needs to be more of a requirement to the extent that states are pursuing this kind of thing.

I think the way the portal is handled doesn't put the beneficiaries in a position to succeed, to comply with the state's policy, to succeed within the rules of the game the state establishes, partly because of the code only being part of the mailing. The code isn't apparently included in those phone call outreaches that are done by AFMC, and they're not apparently part of outreach calls.

And so, to me, the way that beneficiaries seem to be aware of how to create an account, how to use the portal doesn't put people in a position to succeed. The internet issue is a part of that. The hours of coverage of the portal are part of that. And so if you're going to use that kind of methodology by which people report it needs to be, to me, at a procedural level, done in such a way that beneficiaries have a stronger opportunity to succeed within the rules the state is establishing.

And I think I had one other comment I wanted to make, and I want to go back to my notes about this. No, I

think, actually, I've covered off on it. Just to sum up, I'm not going to take issue with the policy here in Arkansas. I do think there are a lot of states that would only do the Medicaid expansion if they could do this kind of thing, and we've seen in the data you presented in September 77 percent of the people who are subject to this, their coverage hasn't been put at risk yet. So that's a win for those people and I don't want to lose sight of that.

But I do think to the extent the states pursue this kind of thing, MACPAC's role, in my view and my opinion about this is our advice to CMS ought to be that they require states to follow procedural dimensions in terms of communication protocols, good cause exemption notices, all of that in a way that put the beneficiaries in the best position to know the program, to comply with the program, and to succeed within the rules of the road the state establishes, and to me that's the deficit in Arkansas that I think I would like to see CMS become more strict about in terms of the terms and conditions for future waiver approvals. And I'll leave it there. Thank you.

CHAIR THOMPSON: Thank you, Chuck. Just to

follow up on Chuck's point, Kacey, can we go to the slide where you talked about the other states that have been approved? I think this is something to think about.

In either Arkansas' or Indiana's or New Hampshire's waiver applications or STCs, do we have visible the kinds of dimensions that you spoke to you in your paper and the things that Chuck is reacting to? In other words, would you know, from reviewing either the waiver as it was submitted, or the approval document that CMS provided, how a state was going to handle good cause exemptions, or hours of a portal, or the availability of various channels, or how the education and outreach was going to be handled?

MS. BUDERI: The STCs contained some requirements around minimum notices that need to go out. For example, the state is required, by the STCs, to send out notices to beneficiaries that are tailored to that beneficiary. They need to say you're exempt for this reason, this is when your exemption might end, under these circumstances, or you're required to report activities, here are the activities that qualify.

In terms of the kinds of outreach past that, I don't believe the STCs require something like a beneficiary

relations contractor making a certain number of calls. So you wouldn't know about any kind of supplemental outreach strategy past those formal notices, I believe. And then good cause exemptions, the STCs contain a minimum list of good cause exemptions that the states need to provide. I think it would be fair to say that Arkansas, you know, the states have discretion to grant good cause exemptions for reasons beyond the ones specified in the STCs. But the STCs don't say, for example, that beneficiaries need to know about the good cause exemption in the earlier notices. It just says that they have to allow -- they have to provide for a good cause exemption.

CHAIR THOMPSON: Yeah. I'm just trying to bring home the point that to the extent that we want to weigh in on or identify those areas, we're talking about a level of operational detail that generally contained, if at all, within protocols, that the state may develop, maybe with approval of CMS or not. So it won't be clear, for example, on some of the things, unless CMS decides that it wants to make it clear, and that's, I think, a point of conversation, on a group of waivers happening again in a very contained period of time where there is a lot of

potential impact, that the level of detail around exactly how things are going to be handled and who is going to see a notice, at what point in time, and what is it going to look like, and who are we going to engage to help us educate beneficiaries, and all of those kinds of things, that those decisions are generally made at the state, and maybe without any kind of federal scrutiny.

And so what we should talk about, if we want to get to that level, are we talking about, you know, again, frameworks or rubrics or protocols, or is it transparency for comment, or is it best practices, and, you know, those kinds of things.

MS. BUDERI: Can I just clarify one point? Arkansas did submit an eligibility and enrollment monitoring protocol which does contain a lot of the information that you're talking about, around, like, for example, a lot of the stuff about AFMC is contained in that protocol.

New Hampshire is also required to submit one of those protocols and make that publicly available, but I haven't seen that yet. It's not publicly available yet. Earlier states with approvals, including Indiana and

Kentucky, when they were initially approved, did not have that requirement to do a protocol like that and make it publicly available. So I just want to make sure that you have that information.

CHAIR THOMPSON: So there is, in fact, a mechanism that CMS has used with Arkansas that contains some of these details.

MS. BUDERI: Yes.

CHAIR THOMPSON: Okay. Good. All right.

COMMISSIONER MILLIGAN: Can I -- I'm sorry. I won't take long this time. But I want quibble with just -- suggest an edit to one slide, Kacey, which is Slide 8, and I think it kind of gets at some of this -- sorry, Anne. I don't mean to accidentally read the materials.

I think it's more than a semantic thing. I just want to kind of flag for you. The title is "Non-Compliance among Beneficiaries without Exemptions." So in your first bullet you talk about 91 percent of non-exempt beneficiaries were non-compliant. We don't know if they're non-exempt. We just know that they haven't reported an exemption. And so, to me, this is where the good cause issue plays in, is they might have an exemption but it

might just not be a reported exemption.

EXECUTIVE DIRECTOR SCHWARTZ: There's also a difference here. There's a difference between being exempt from the requirements and the good-cause exemption for reporting, though. I just want to make sure we're not mixing them up.

CHAIR THOMPSON: There are actually too many versions of the word "exemption" in this program. But because, you know, you're subject to the requirements you are not subject to the requirements. If you are subject to the requirements you may not need to report because the state has found the information it needs. You may need to report. If you don’t report you may request a good cause exemption. I mean, it's hard for us to understand.

And, you know, again, I think it becomes very interesting to look at some of these data in terms of it's not just, Chuck, that they may be exempt but didn't report it. They may also be compliant but didn't report it. So that's part of the distinction to make here about what do we know about people in terms of their experiences. Are they simply not reporting or are they, in fact, not meeting the requirements? And if they don't meet the requirements

is it because, other than work, it's hard to cobble together, for example, some of the things that you can use to meet the requirements, in terms of education or volunteer work, et cetera.

So, I mean, there's just a lot that we don't know.

Let me ask Darin to weigh in, and then what I'm going to do, we're going to go over time. We know this was going to happen. I'm going to ask Darin to weigh in, and then I have Kit, Sheldon, Kisha. But before you guys I'm going to ask the public to jump in so that we give them an opportunity.

All right. Darin.

COMMISSIONER GORDON: Just for fun I'd like for you to go Slide 25 and then Slide 2, but I'm really just -- I'm not going to make you do that.

I agree with a lot of the comments Chuck has made and Penny has made, and some of the points that Alan has made. I think one of the underlying things -- and we tend to see this far too often, actually, in Medicaid -- is the unrealistic expectation on time frames from approval to implementation. And so some of the things that are

following some of the gaps, whether it's around education, outreach, data collection, processes put in place, is a result of not ensuring that there's adequate time to put in place these types of mechanisms that I think are necessary with any kind of new program implementation. And I think that's one of the things that we should consider weighing with CMS, about ensuring that there's been thoughtful consideration to what an adequate or appropriate implementation time frame should be, given that they, at the CMS level, will see how different states approach this and will have some sense of what that time would be.

Secondly, you know, this population has historically been difficult to outreach, and it's a challenge on a lot of levels. It happens at redetermination quite frequently. And I think given that there has to be certain mechanisms in place for that reality, there are things that you can do. Multiple approaches to communicating is ideal, and having only one way to report compliance through the portal. Again, there are a lot of things Arkansas did, I think, that were helpful and done well. Again, we have the benefit of looking at it in hindsight and seeing some things that

could have been additive to improve how this has been approaches. But multiple avenues by which to communicate but also multiple avenues for which to report compliance I think are necessary.

But regardless of how well you do there -- and let's say Arkansas did a great job -- there's always going to be situations where individual somehow did not get the communication or did not have the avenue available to report their compliance or why they should have an exemption. And so there has to be a process for individuals. And we've seen this in redetermination, where they have the ability to come back and be able to provide their proof or documentation of why they did, in fact, comply or meet the expectations. And I don't know what those processes are or if those were put in place but I think that's something that needs to at least be considered and thought through, because that is just the reality of communication with this population.

I think a lot of the points around the good cause that Chuck made were appropriate, and that was my point is like how else are we communicating those things? How early are we communicating those things? Again, some of that

wasn't included in some of the other notices. Some of it is just, again, the rapid nature of a rollout of a complex program.

The other thing that I think we should think about in recommending to CMS is there are certain data elements that I think are helpful in evaluating these things, that should be some kind of baseline expectation around certain data collection around this, so that, to Alan's point, you would have the components with the information that would, you know, support a more robust research design. And often with these programs you have to build those in on the front end and know what you're going to collect in order to have that information later. It's not something you can do retrospectively.

So making sure that, you know, thinking through, looking at what we're learning from Arkansas, there are questions you can't answer that I think the Commission believes would be helpful in understanding a more complete picture of what's going on. So that would be another recommendation.

And then, you know, the point about strong handoffs to the other resources, you know, just saying you

should go talk to this resource hasn't proven to be the most effective way but it's something else that needs to be thought through as other states are aligning. Again, it's a lesson learned that CMS can help offer others.

The comment, you know, that Penny made early on about the rapid cycle improvement, and, Alan, your point about the robust research, I see those both being necessary, because we have a tendency to wait too long to extract learnings of new program implementations and hand them off to other states who are contemplating these things. And in some cases it's a, well, let's wait for the more robust research design that's several years out, and then you have a state at the starting gate and proceeding down a path that could have benefitted from some of the wisdom of those who had gone before them, about how to avoid other pitfalls.

So I think that is a good role that CMS could play, and seeing what they're learning from some of these earlier states, to make sure that those components, whether through STCs or in what form or fashion, that they're ensuring that there is that exchange of the lessons learned so as to avoid missteps that could have been prevented in

the very beginning.

CHAIR THOMPSON: Okay. Let me take a pause here and then invite the public to come up for any commentary that we could take into consideration as we continue and then complete our conversations on this subject.

PUBLIC COMMENT

* MS. KRESS: Hi. I'm Marielle Kress from the American Academy of Pediatrics.

First of all, thank you for spending this much time on this issue. I completely agree that this is not a one-state issue. This is clearly going to be a precedent-setting policy that obviously many states are going to be taking up and not just in expansion states but in non-expansion states where parents at extremely low levels of poverty are going to be subject to these requirements. And pediatricians are quite concerned about that and the effects that that will have on children. I think that's the first point I want to make.

The slide says the state is not collecting data on downstream effects of coverage losses. I think we have very good data to show that when parents have coverage, children are more likely to have coverage. And so I think

we should maybe take a look at what's happening to children. I think we also have data on the facts that if parents have coverage, children are also more likely to get well child visits, so it's not just coverage. It's care. So I would encourage MACPAC to look at the impacts of the other populations in the Medicaid program.

And then the other thing I just wanted to say is that I think MACPAC has a really unique role and voice on the Hill, and I know that folks and staffers on both sides of the aisle use your data and your analysis, and it cuts through so much of the other information that they're bombarded with. So we may have an opportunity for oversight in the next Congress, and having your voice out there to provide that information and that analysis to the Hill, I think is invaluable. So I would encourage you to do so.

Thank you.

CHAIR THOMPSON: Thank you, Marielle.

Kelly.

MS. WHITENER: Hello. Kelly Whitener with Georgetown Center for Children and Families.

I haven't seen you guys since the CHIP debate,

but it's nice to be back. And I want to echo what Marielle said about just really appreciating the time and attention you're putting into this matter. It's obviously really complex.

I want to kind of echo some of the comments made by the Commissioners that the evaluation component and the fact that there isn't one is very alarming in this process, and yet the data that has come out so far is painting a pretty clear picture of what's happening with over 8,400 people using coverage and expecting to continue to see about 4,000 people losing coverage very month. It's kind of clear what's going on.

If you start to parse through some of the data that has been posted, you can see that the number of people actually coming through the portal and reporting something amounts to about less than 1 percent. Between the automated exemptions and all the different types of exempt ways, you're really not seeing a lot of new people showing up to report new work. You're seeing kind of a duplication of accounting, people that are already meeting a SNAP benefit, but they're calling that new. So there's some kind of funny business going on with those reports, and I

think it's important to take a close look at them.

Another point about those reports is that though they are useful and voluntary, they are not posted to the state website as far as I'm aware. They're distributed to a small group of people.

We've been posting them to our website because we think it's important for people to be able to access that information, but it's not actually as transparent as it should be. And I think CMS is doing a disservice to the public by not requiring a robust evaluation up front and more robust data along the way that is publicly available and more to just a select group.

Then I also want to echo what Marielle said about the application of these work requirements potentially to very low-income parents and the pipeline CMS has before them, a number of requests looking to expand work requirements -- or looking to impose work requirements since states that have not expanded and are not considering expansion as part of that debate. So you have states like Alabama and Mississippi where the coverage eligibility levels are very low and wanting to expand a work requirement there, which would be very damaging to children

and families, far beyond what we've even seen so far in Arkansas.

So I just really encourage you to think about the platform that you have and the ability that you have to weigh in to both the administration and the Hill and to have your voices be heard and not to let that pass you by.

* CHAIR THOMPSON: Okay. Let me return back to the Commissioners, then, and pick it back up with Kit, Kisha, and Sheldon, and then I'd like to check in and see if there's anybody else, maybe, Alan, come back to you because you said you wanted to hear. I'm going to put you on the spot and give you advance notice because you said you wanted to hear before you -- and then maybe suggest a path forward in terms of the immediate and the longer term.

So, Kit.

COMMISSIONER GORTON: So I agree with an awful lot of what's been said, and I won't reiterate. I think my head is most closely aligned with where Chuck was coming from and with some of what Darin said.

I want to start by saying that I have great sympathy for Arkansas because I was on the front lines of managed care rolling out in Pennsylvania, and we were told

there would be blood in the streets of Philadelphia. So I get that this high-scrutiny period that you're talking about is painful for them. That doesn't mean that they shouldn't do their demonstration.

But they should do it well, and they should think about decisions that they've made that add risk, perhaps unnecessarily, to the program.

The single communication channel adds risk. The lock-out adds risk, and I'm not saying that you wouldn't grow into the lock-out at some point. But often as we've rolled out these big program changes over the years, we've sort of baby-stepped our way into it, and this one seems to have been born fully formed from the head of Zeus and in a very, very, very short time frame.

So I do think that there are things that have been added to this program decision that increase risk and which put Arkansas in the hot seat, which might have been avoided and should be thought about both by Arkansas and by other states who are moving down this path.

And I would underscore what Darin says about don't go too fast. Everybody always tries to go too fast. It gets in the way. Roll these things out gradually and

pay attention.

I do want to absolutely align myself with something that Alan said, which is, Where is the program evaluation plan?

And that brings me to the point that I really want to make, and I do think that we should write to the Secretary. And I think we should write to the Secretary, and we should say, "Why the heck did this thing go live without an evaluation plan? Why are these things not in place? Why is the data not being collected as a baseline?"

We'll see what happens here, but I think the idea, which I personally think is worth exploring -- I get that there's not any evidence out there, but it's worth thinking about, something that's front-of-mind for an awful lot of people: Shouldn't people on Medicaid have to work, make a contribution to their communities?

So let's explore it, but let's explore it properly, which means collect baseline data, set up comparison groups, get your evaluation criteria, hire your vendor, do these things, and then turn the switch.

So I think CMS had an opportunity that they missed, but they should rethink it in terms of what they

put in place before they let folks go live. I agree with Penny's description of the sort of incremental roll-out of STCs over time, and I don't think that CMS should sort of smother these things in the cradle and not let people come and experiment and test things out. But I do think that -- and I've said this before; others have said this before -- one of the failures of the 1115 process is that too often, we get 5, 10, 15 years into it, and we still don't have any data about whether the fundamental premise works or doesn't work, and I don't think we should do that here.

So my point of view would be we should say to the Secretary or to the Administrator, to whoever this is properly addressed to, "Time out." This is a very important topic. It's a front-of-mind for an awful lot of people. Let's do it right, and let's hit the pause button, not forever and not in response to what we're seeing in Arkansas, but simply because we're not ready to dance here. So that would be my perspective with many of the comments that other people have made.

Implementations are always ugly. They're always less ugly if you take a little more time and if there's more data.

I guess one other thing I would say to CMS -- and, again, thank you to Arkansas for being as transparent as they're being, and I hear the comment from the public about it can always be more transparent. It can always be more transparent, but there are reasons why it isn't, and so I appreciate the transparency that Arkansas has brought to the process so far.

I personally would feel better -- not if we saw more reporting, but if we had some level of confidence that CMS was seeing some reporting. I'm glad that CMS is talking to the state, and I'm hopeful that they're talking about substantive things. But it would be more helpful to me, even if you can't produce high-quality reporting because it doesn't meet the standards of public reporting, blah-blah-blah, that we all know about, but can you at least tell me what you're talking about? Yeah, we get this. We understand that if our whole communication path is based on sending people written notices and we have a bad address, that, in fact, we have no communication path, and we're going to figure out what we're going to do about that.

So it would be useful for CMS to say -- and this

is my final comment. The issue here to me is less one of an accelerated program implementation and more one, which I think is germane to this Commission's role, of is effective over sight in place, and my crisis of confidence here is not that Arkansas won't take care of its people as best it can, because I believe that. But I do worry that CMS does not have its head in a place and the resources arrayed to oversee this kind of demonstration and certainly not on a broad scale across the country, and I think the Commission is entitled to reassurances that they're thinking about that.

CHAIR THOMPSON: Thank you, Kit.

Kisha and then Sheldon.

COMMISSIONER DAVIS: Thank you.

I think I can be brief and concise because of many of the comments that have already been said.

I want to echo a lot of what Kit has been saying about I do think it's our place to write a letter to the Secretary of HHS to really talk about where are the lapses in evaluation and why wasn't that done from the beginning and how can we back-roll some of that and is it necessary to slow down or pause or implement some of these things to

look at the program and where the lapses were.

I'm especially concerned about, in doing some sort of evaluation, looking at what are the downstream effects, so what's happening to these people that are disenrolled, what are their health care costs now, are their uncompensated care costs going up in the state because of these folks that are now being kicked off the roles, also thinking about is it actually increasing work.

I mean, there's no data that's actually looking at is this having an effect on people working in the state, and so if that underlying hypothesis is that this is going to encourage more people to work, are we actually looking at that and seeing if there's any outcomes around that?

Then the last thing is looking at reenrollment cost. For these folks who have been disenrolled and then now the following year after the lockout period are able to reenroll, are their costs now higher because they've delayed care for X amount of time? And so what does that look like for those enrollees?

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: Thanks.

I will be brief, but I refuse to be concise. I'm

just not going to do it.

[Laughter.]

COMMISSIONER RETCHIN: I share everyone's view about the work requirements, and we have now 25 years of experience.

That said, I understand that some states are interested in work requirements for Medicaid eligibility; however, I am uncomfortable being held hostage on the expansion idea since there are so many non-expansion states now standing in line for similar waivers. The administration has signaled that there's an interest in that.

So I do think that they should be evaluated, and I don't rule out the idea. However, in that regard, I'd like to know what the hypothesis is. Is the hypothesis that work requirements lead to higher employment rates, which the Heritage Foundation has said absolutely not, that it doesn't work, or is it to disenroll recalcitrant, non-exempt eligibles? So I think that may be cynical, but it's important to tease out and does need to be evaluated.

But I really get down to the role idea of the outreach, which there's a couple of things to make a point

on this.

First of all, Arkansas is the eleventh worst state in terms of internet access, and many of the states that are in line for work requirements and major policy changes have very bad internet access. Still, a third of Arkansans and 25 percent of Americans do not have internet access at home. So that restriction alone to me is the pause button.

But I am reminded of another major policy rollout where there was major criticism and disruption over the ability to contact potential eligibles, and that was the marketplace exchanges. Man, there were congressional testimonies. People's careers were put on the line, and it was all over the rollout. As a result, there are today five different methods that someone can access the marketplace exchanges.

Restricting this portal to only online access, I think is fundamentally flawed and will be in states that are dominantly rural. I think that alone to me is worthy of a pause.

CHAIR THOMPSON: Okay. Alan, I am going to circle back with you, give you one more chance, and then

I'm going to try to make a proposal.

COMMISSIONER WEIL: My only direct reaction is I'm certainly aware of the politics of the tie between work requirements and expansion or retention of an expansion.

I'll just say what's often been said about the Medicaid program, which is if you want to do something that's not in the statute, change the statute. It's been done quite a few times. So I don't want to just use the politics to sort of release any tie to the statute.

What I'm hearing is a lot of concern about the operational side, which was not really the focus of my comments. You asked me to re-reflect, and what I would say is I do think I'll stand by what I said earlier, which is I would call a pause on new states. I really would, but I think our legislative charter is to make recommendations to the Secretary and the states.

Based on what I'm hearing here, I would say that we have significant concerns about whether or not the hypothesis is clearly stated and whether or not we'll learn from it. That feels pretty abstract to me. I mean, I have to say these are people's lives, and this whole conversation has felt very abstract. But when I listen to

colleagues, what I hear is agreement on concern about whether or not we'll learn and not so much agreement on concern about what's happening so far, other than as an operational challenge.

I would say we ought to say to the Secretary and to the state that while we appreciate the transparency that has occurred thus far, we're very concerned that given what we've seen, it's not going to be clear whether or not the premise of this policy is accurate. Maybe in our next meeting, we'll say something stronger than that, but that would feel to me like a start.

CHAIR THOMPSON: Stacey.

VICE CHAIR LAMPKIN: Well, I just wanted to say maybe part of it, even if our comments are operational and around about -- they're set up by saying this is not just any kind of policy area. This is a policy area with significant implications on people's lives and health, and it's in the setup of the argument that we can make the case that these are people's lives, really.

CHAIR THOMPSON: Melanie.

COMMISSIONER BELLA: Sorry. It's just the deja vu. I can't help but say because this feels somewhat like

duals demo. It's different, but it's a complex program. It's hard to understand, and there's criticism of it going too fast. So I just have to comment.

I think it's important for us to consider pause on the new states. I also think it's important for us to consider pause here.

I can only go on the demonstrations, but when there were problems, we stopped enrolling people in a particular state. Just like here, you would stop until you got something fixed, and there was a very prescriptive process on the front end of readiness review of a state to do something new, which is in line with kind of more of the operational, but also sort of the evaluative piece.

So I think as we consider pause, I would just encourage us not to think about pause future, but think about pause of what's in front of us. Whether it's duals demos or other things, there's precedent, certainly precedent for doing that from the agency's perspective, while respecting the state.

CHAIR THOMPSON: Yeah. It does happen on a rare basis and much easier to pause moving forward than to pause ongoing.

So this is what I would like to suggest, based on what we're hearing. It sounds like, first of all -- and I'm going to highlight a couple of places where maybe we have a disagreement or maybe we have different views, and I want to tease that out, give everybody one more time to tease those points out.

So I think it's clear we want to write to the Secretary. We want to express concerns about the early returns from Arkansas. We want to point to this being not just about Arkansas. If Arkansas was the only state in the nation that was doing this for the next five years, it probably wouldn't have merited the amount of time and attention that we're giving to it at the last meeting and this meeting. So it is the fact that it's an early return on a program feature of significance with big impacts on beneficiaries, where we will have potentially a fair number of states wanting to move forward in various ways, and so it becomes really important to try to extract every bit of lessons and early indication that we can from the state that has gone live.

We have a bunch of things that I think we don't need to repeat about observations on kind of the process

and places where we think maybe more attention needs to be paid and more opportunity exists for improvement. We have some general observations about giving things enough time, thinking about phasing, reducing the risk associated with a new program feature on populations that could help ensure smooth operations and improve the overall objectives of the program.

There are some Commissioners who may question the underlying hypothesis, but even taking the underlying hypothesis as the approved basis of the waiver, we are concerned, as we have been for some time, about monitoring evaluation of 1115 waivers that were not getting the right kind of demonstration setup and research framework and baseline data and agreement on measures that will set us up for success in terms of understanding whether our hypothesis is correct and doing so in a way that is robust and timely.

That does not mean, I don't think -- but this is Penny in a parenthesis here -- I don't think that means that we need everything -- the contract, the scope, the measures -- everything set up in advance, but I do think you need enough set up in advance so that you can

successfully evaluate. So in sort of the same way that, Chuck, you were saying about beneficiaries need to be set up to succeed. The research hypothesis, the evaluation framework, and the methodology needs to be set up to be able to provide timely input. I think that's all reflective of a fairly broad consensus among the Commissioners about what we would say in this letter to the Secretary.

Here's maybe two places where I heard maybe some differences. One is pausing. So I invite some more commentary on this, which is the way that I would put it is all of this means it may take more time to approved a waiver or to go live on a waiver, and we think that time is worth it. How much time that takes, how it applies to a specific state that may be having submitted a waiver -- in other words, I'm concerned pausing suggests everything stops until everything is figured out, and I don't know that we're ready to say that on the basis of one state with a particular approach and early results.

And so I think I would be more comfortable with a statement that says we just think the investment in thinking through these things and addressing some of these

issues is worth the time that it may take. It will pay off in the end. The question of how much time is that and what do you really need to do and how much of this could be ready or is ready is something that the Secretary should think about.

So that's one point I want to invite some more commentary on. That obviously means we're not making a particular commentary on Arkansas per se, in terms of whether -- I mean, we can point out that we believe that Arkansas should also think about these kinds of things, but that relates to the second point where we may have some difference, which is I would not suggest that we're writing to Arkansas. Now we have a mandate where we make recommendations to states that could be seen as inclusive of recommendations to a state. We would certainly share this conversation and the letter with Arkansas. But to me the primary audience for our comments at this time would be the Secretary.

So let me just open those two points up, and any other others that folks think want to tweak a point that I said. Kisha and then Martha and then Fred.

COMMISSIONER DAVIS: I think, to your first

point, about the overall pause in the program I definitely agree with that. I do think that there is a place, though, to say -- and maybe it's to Arkansas or maybe it's to CMS -- that maybe disenrollments need to be paused until they can work out some of the operational issues around access and portals and mailings and all of that, and is there some slowdown that needs to happen there before another 4,000 or 12,000 are kicked off the rolls.

CHAIR THOMPSON: Okay. Martha.

COMMISSIONER CARTER: I'm going to add a little anecdotal information. The community health centers, to your point, Sheldon, have outreach enrollment specialists to help people with the Marketplace, and they also help with lots of other program eligibility. So I reached out to a colleague in Arkansas who coordinates the state-reach outreach and enrollment folks. And what they're hearing is that people just don't know that they were eligible or they had a requirement. And the health centers provide care for 75,000 non-CHIP Medicaid people in Arkansas.

So I'm not sure to the extent that the health center outreach and enrollment people were involved in this process but I'm coming down on the side of pausing the

disenrollment so that there's more time for the state to improve their processes around reaching this population that's very difficult to reach, and then including that requirement in the upcoming applications, waivers.

CHAIR THOMPSON: Melanie, and then -- I'm sorry, Fred, I skipped over you, so go Fred first, then Melanie.

COMMISSIONER CERISE: I just would -- I'm aligned 100 percent with Alan on if this is a demonstration and you don't have a way to demonstrate what you're doing, I would encourage no more of these until you have a solid demonstration plan. But also change the statute, like you said, and say that's not what we're going to do, but do one of the other. I would not focus so much on the technical issues surrounding -- I mean, I know those are real issues but I think there's a bigger fundamental question here.

CHAIR THOMPSON: Melanie.

COMMISSIONER BELLA: Yeah, I agree there is a bigger fundamental question but there are a lot of people like right in front of us that are losing coverage. And so I guess I don't mean we should stop working on these things, right, but there's a way to make them stronger and there's sort of a continuum of things that could be done to

do that. It's unfortunate that there wasn't more rigor on the front end, to make sure that these systems were in place and beneficiary notices had been tested and all these things, but it didn't happen that way.

And so this just feels a lot different to me, that it's not like we're moving someone into managed care and they might lose access to doctors. We're taking them off the program. And so I don't think we should take pausing the disenrollment in Arkansas off the table. Or if we don't want to pause the disenrollment maybe we say please get an ombudsman in place, you know, there's other things. Reduce the lockout period. I mean, they've gone to such an extreme here, you're off for the whole rest of the year.

And so there's different things. I think if we don't want to go all the way on pausing on disenrollment put something in there that requires making sure beneficiaries understand this better and maybe not make the consequences so harsh until we're sure that some of the other processes are in place.

I realize this is states' rights. I get it. Like I don't like to trample on states' rights either. I

like Chuck's lens about make people successful within the rules that the state has chosen. And if we could do that -- I just think we didn't have enough enforcement of any sort of standardized set of expectations on the front end to make sure that the rules the state chose were ones that people could succeed it.

CHAIR THOMPSON: Chuck, did you want to respond? Okay. So let me do Kathy, Toby, then Chuck.

COMMISSIONER WENO: I just wanted to add my voice to the pause contingent of the group. I would say, you know, as a former legal aid attorney, this whole loss of coverage is really concerning to me, and I also would say, you know, I do want to give credit to Arkansas. It sounded like they did do a considerable outreach effort. I mean, it just didn't work that well.

So I think we need to, you know, evaluate that, try and figure out a better way to do outreach to this population, but then also looking at the other states that are in line for that, so they can also address that issue before they try and try it.

CHAIR THOMPSON: Toby.

COMMISSIONER DOUGLAS: So first I struggle

considerably with the idea of us getting involved in states. These are a lot of state policies that the balance between the overall goal, whether it's expansion, whether it's how to continue benefits or ways of moving fast at managed care, there are multiple times this occurs. But there's this balance here, as well as doing it right and figuring out how to continuously operate and improve, and as Melanie said, the duals are many times experiences of continuously improving and changing the process and pausing and changing.

And so that's what we have here, and I struggle to see how we can pause on future when we have one right in front of us that is still fundamentally going to set the framework, and yet right now we're seeing no ability to evaluate. And so why not pause that too, work on ways to continuously improve the process of outreach engagement, all the different structures within it, as Chuck said on processes, and then we can evaluate all these in a way that tests the hypothesis.

CHAIR THOMPSON: Chuck.

COMMISSIONER MILLIGAN: I just want to align myself with the notion of a pause too. I just want to make

sure that we were clear what we're going to recommend pausing. I do think, for the ones in the pipeline, the pause would take the form of don't approve it until there's a research design and evaluation method. And so there's a pause for the stuff in the pipeline.

I think with respect to some of the discussion about the pause, with the recommendation with Arkansas about disenrollments being paused until some of the other kind of infrastructure catches up, I'm supportive of that as well. So I just wanted to align to some of the comments I've heard.

CHAIR THOMPSON: Okay. So it does sound like we have actually a view that HHS should take the time before approving additional waivers, that it establish the evaluation framework, that there be some early data collection, that they examine and discuss some of these dimensions of operational performance that we've seen, some good, some maybe could be better, based on Arkansas, and that they work with Arkansas to pause the process to avoid harm to beneficiaries while adjustments are made inside of that waiver with regard to either reducing the penalty associated with reporting or doing some follow-up to ensure

that the people who are not reporting are not reporting because of barriers to reporting, and providing some additional information to CMS about those beneficiaries and those processes.

Okay. All right. So let me see if anybody has any additional thoughts at this junction. We did go a little over time. Let me ask the public for comment.

[No response.]

CHAIR THOMPSON: Okay. Great. Since we are behind let me just make an adjustment to the afternoon schedule, because we're not going to start again in 20 minutes. We will give ourselves until 1:30. Will that be enough time for lunch? All right. Why don't we give ourselves until 1:30. We'll pick back up then. For now we are adjourned.

* [Whereupon, at 12:55 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION

[1:34 p.m.]

CHAIR THOMPSON: Okay. Welcome back, everyone. And now we're going to start the afternoon by taking up a Notice of Proposed Rulemaking on public charge.

I just want to make a couple of introductory comments about the rule. Generally speaking, when we're discussing commenting on rules in this Commission, we're commenting on rules issued by HHS. In this case, this rule is issued by DHS. It's primarily about immigration, something that we don't have a particular charter to comment on, but it obviously implicates and potentially impacts access and delivery of care in Medicaid and CHIP, which is our purview and is something that we should and do comment on in terms of rulemaking.

So we'll have a discussion about what the parameters of our potential comments could be following Martha's presentation on what the rule is and does. And then we'll have an opportunity for the public to comment and finally settle on our direction for the commentary that we wish to make.

Martha?

PROPOSED PUBLIC CHARGE RULE: EFFECTS ON MEDICAID AND CHIP

* MS. HEBERLEIN: Thank you. So on October 10, 2018, the U.S. Department of Homeland Security issued a proposed rule that would change the definition of public charge for purposes of immigration status. While the proposed rule, as Penny said, does not make changes to the Medicaid regulations, the changes that it does make are likely to have implications for beneficiaries, providers, and states nonetheless. So we'll spend the next session discussing the rule and the potential implications for Medicaid. I will begin today by discussing immigrant eligibility for Medicaid before providing some background on public charge, the proposed changes in the rule, as well as the potential effect they might have on Medicaid. And then I will discuss potential areas for you all to comment if you choose.

So, to begin, in order to qualify for the full range of benefits offered under Medicaid, individuals must be citizens or nationals of the United States or qualified aliens. The term "qualified alien" was created by the Personal Responsibility and Work Opportunity Reconciliation

Act of 1996, also referred to as "welfare reform." It includes lawful permanent residents, refugees, and asylees, among others.

Lawful permanent residents entering the U.S. after August 22, 1996, are generally barred from receiving full Medicaid benefits for five years, after which coverage becomes a state option, and this is an option that most states have adopted.

Children and pregnant women who are lawfully present may be covered during the five-year bar, also at state option, and as of January 2018, 33 states had adopted the option for children and 25 had adopted the option for pregnant women.

Non-qualified aliens as well as qualified aliens who are subject to the five-year bar who meet income and other eligibility criteria for the program can only receive limited emergency Medicaid coverage.

So the Immigration and Nationality Act requires that an individual seeking admission to the United States or seeking to change his or her status to lawful permanent resident is not admissible if at the time of application for admission or adjustment is likely at any time to become

a public charge. Not all applicants are subject to a public charge determination. For example, lawful permanent residents who already have their green cards and are seeking citizenship as well as refugees and asylees are specifically exempted from the process.

Under policies that have been in effect since the late 1990s, "public charge" has been interpreted to mean that the individual is primarily dependent on the government for subsistence. This is demonstrated by the receipt of cash assistance or institutionalization for long-term care at government expense. Short-term institutionalizations for rehabilitation and current or past receipt of non-cash benefits are not taken into account. So non-cash benefits, which include Medicaid and CHIP, are considered to be supplemental and do not make a person primarily dependent on the government for subsistence. And then inadmissibility is determined based on the totality of an individual's circumstances.

So as I mentioned, earlier this month the Department of Homeland Security issued a proposed rule that would change the definition of "public charge" for purposes of immigration status from what is currently in effect.

Specifically, the proposed rule would change the definition of who may be considered a public charge from someone who is primarily dependent on public benefits to someone who receives one or more public benefits. Public charge determinations would continue to examine just the individual and not take into account benefits received by family members, and this is a change from an earlier draft of the proposed rule.

In addition, the proposed rule would expand the list of public benefits that can be considered in a determination of public charge to include Medicaid. Receipt of Medicaid would be considered a public benefit under the proposed rule if an individual received Medicaid for more than 12 months within a 36-month period or received Medicaid for more than nine months if the individual also received a so-called monetized benefit such as cash assistance.

Certain benefits, including emergency Medicaid, school-based Medicaid services, Medicaid benefits provided under the Individuals with Disabilities Education Act, or IDEA, and Medicaid for certain children of citizens with citizenship pending, such as foreign adoptees, would be

excluded from the public charge determination.

CHIP is not included in the proposed list of public benefits, but the department is seeking comments on whether or not it should be.

Consistent with the earlier guidance, the department will continue to consider institutionalization at government expense as a public benefit.

Under the proposed rule, immigration officials would continue to consider the totality of an individual's circumstances in making a public charge determination. Under statute this must include the individual's age, health, family status, assets, resources, education, and skills. The proposed rule describes how these factors would be considered and whether certain characteristics would be considered positive factors that would decrease the likelihood of becoming a public charge or negative factors that would increase the likelihood of becoming a public charge.

An assessment of the financial status of an individual would also include consideration of whether he or she has applied for or received Medicaid. In addition, the proposed rules would weigh certain factors more heavily

than others. Among those heavily weighted negative factors is current or past receipt of Medicaid within the last 36 months.

So moving on to implications, as discussed at the beginning, the proposed rule does not change Medicaid, but including Medicaid in the determination would have implications for the program. So starting with the beneficiaries, the proposed rule would likely have a direct effect on individuals awaiting a decision on their application to either enter or stay in the United States. The DHS estimated that among those already present in the U.S., 382,000 green card applicants and 517,000 applicants for other types of visas would be subject to the new public charge criteria annually.

It is unclear how many of these individuals would be deemed inadmissible on public charge, but estimates based on immigrant use of benefits suggest that the share of non-citizens subject to a public benefit determination would increase if the definition were enacted.

In addition, given the potential consequences for the immigration status, individuals who are legally entitled to coverage may choose to disenroll or not enroll

because of fear or confusion, a so-called chilling effect. This hypothesis is supported by anecdotal evidence. For example, there have been a number of recent news reports that have noted the fear of public charge affecting take-up among public programs. Also, in a recent study involving interviews with families, immigrants have expressed fears that participation in Medicaid or other programs could jeopardize their immigration status.

The experience from welfare reform is also illustrative. Following welfare reform in 1996, there was a sharp decline in immigrant participation in public benefits. The decline was due to the fact that the law restricted eligibility among recent lawful permanent residents, but the legislation also served as a deterrent to enrollment for many immigrants who remained eligible but did not apply out of fear for the negative immigration consequences of being determined a public charge.

The confusion following the changes in welfare reform resulted in some negative public health consequences and led in part to the earlier guidance that I outlined before.

A body a research shows that the declines in

enrollment in public benefits range from approximately 20 to 60 percent, depending upon the benefit that was looked at. For example, one study found that the use of Medicaid among non-citizen households fell by 22 percent between 1994 and 1997. Among non-citizens with income below 200 percent of the federal poverty level, participation in Medicaid declined 19 percent during this time period. Declines were also seen among populations that were not subject to welfare reform, including citizen children of non-citizens and refugees.

A recent study estimating the effects of the proposed rule suggests that if disenrollment ranged between 15 and 35 percent, 2.1 million to 4.9 million Medicaid and CHIP enrollees in families with at least one non-citizen would disenroll. The chilling effect could also extend to citizen children. In 2016, there were 10.4 million citizen children with at least one non-citizen parent, and of these, 5.8 million had Medicaid or CHIP. Assuming similar disenrollment rates, an estimated 875,000 to 2 million citizen children with a non-citizen parent could drop coverage despite being legally eligible.

To the extent that the proposed rule creates a

barrier to coverage, it is likely to result in increases in uncompensated care among providers such as hospitals, community health centers, and other providers as they see an increase in uninsured patients.

Furthermore, immigrants and their families may forgo preventive or routine care, which could lead to an increase in more costly services. The department acknowledges that the rule could result in reduced revenues for health care providers participating in Medicaid.

Implementation of the proposed rule could also affect states. First, it is not clear how the department plans to track individuals' use of public benefits, whether it will be the responsibility of the various state benefit agencies, and whether that information can be shared across entities. The rule acknowledges that agencies may need to make changes to forms, procedures, and systems, and seeks comments on what might be necessary.

Second, states may find it necessary to take other steps, for example, to conduct outreach activities, change notices, and alter other procedures to advise beneficiaries of the potential immigration consequences of enrollment.

Finally, the decline in enrollment anticipated in the proposed rule could have fiscal implications due to loss of federal Medicaid funds and increased costs for uncompensated care and other state services.

Finally, as I mentioned, the rule does not currently include CHIP as a public benefit but seeks comments on its inclusion. If CHIP were added, the implications that I just went through for Medicaid, such as the coverage losses and state and provider effects, would likely be similar to those expected to occur with the inclusion of Medicaid.

In addition, it may be worth noting that families typically do not know whether their child is enrolled in Medicaid or CHIP. As such, it may be possible that enrollment in CHIP could be affected regardless of whether or not the program is included as a public benefit.

Furthermore, as shown in this illustrative figure, states have made different choices as to where to set their Medicaid and CHIP eligibility thresholds. Here the dark bars at the bottom represent Medicaid, the hashed bars are Medicaid expansion CHIP, and the light blue bars represent separate CHIP programs -- or maybe they're light

green. It's hard for me to tell.

Given the varying eligibility levels across the states, the proposed rule could affect children at the same income level differently depending upon where they reside.

So the proposed rule is open for comment until December 10, 2018. The Commission may want to consider commenting on the areas listed on this slide or other areas of interest. If you should choose to comment on this proposed rule, the comments as Penny said, would be confined to issues affecting Medicaid and CHIP as within our statutory purview.

As suggested from earlier experiences, the proposed rule could create a barrier to access for those who are otherwise legally entitled to coverage. The Commission has voiced concern in the past regarding policies that could lead to potential coverage losses, for example, when you discussed reauthorization of CHIP funding.

The Commission may also wish to highlight the effects that a potential decline in enrollment could have on providers and states, including a potential increase in uncompensated care, a decline in federal Medicaid funds, or

potentially additional administrative expenses associated with implementation. And as just discussed, the proposed rule does not currently include CHIP, but the Commission may wish to comment on the implications of its inclusion.

So with that, I will turn it over to you for discussion.

CHAIR THOMPSON: Thank you so much. That was a great summary, and I have a few questions and then want to open it up for more conversation among the Commissioners.

I do think that our contribution here is in helping the drafters understand Medicaid and CHIP. That to me is the big contribution in terms of both as they look -- as they talk about Medicaid, understanding Medicaid in the context of a state program with a lot of variations in how it operates; as you mentioned, how states incorporate or don't incorporate CHIP; if there are impacts that are secondary to the primary purpose that have to do with, you know, what's happening to the safety net system that we can point out other impacts happening to the safety net system that will potentially amplify those impacts. You know, we had a discussion earlier today about DSH reductions and how those are going to be distributed, and sort of pointing out

that those kinds of things are happening. So to the extent that there may be impacts that increase uncompensated care, it should be viewed not just in and of itself, but in the context of these other activities.

A question that I had about something that I don't think I saw in your slides but it was in the paper about -- and this was a point of confusion that I had initially -- about whether it's receiving benefits or applying for benefits, can you just tease that out for us? Because I think there's a different -- an additional set of issues if there is an implication for people who are in the process of applying.

MS. HEBERLEIN: I will do my best, because in my read it is not completely clear how those things will all fit together. So the definition of a public charge under the new rule would be someone who receives one or more public benefits. A public benefit includes Medicaid, which is defined as receipt of Medicaid for 12 months of 36 months. And then further on, it describes how they will weigh different factors in determining whether someone is a public charge. And there they talk about financial self-sufficiency, and they talk about Medicaid. And there they

talk about a negative factor will be whether or not somebody has applied for or received Medicaid. So they talk about it in multiple places --

CHAIR THOMPSON: Both ways.

MS. HEBERLEIN: -- and so how they all fit together, it may be additive --

CHAIR THOMPSON: Okay. To the extent that we're confused, we might want to point out we find it confusing. But beyond that, I think the other thing that we can contribute in terms of understanding the program is that applying for health insurance subsidies is not -- people come and apply for help. They don't necessarily come and apply for Medicaid. So if you come to the federal exchange as an example, you're getting assessed for all sources of coverage and, depending on your state, you may get a determination that you are eligible for Medicaid, whether you thought you were asking for that or not.

So I think -- and, in fact, you know, of course, the ACA laid out this idea of a seamless, integrated eligibility process and system that was not program specific. So that, of course, becomes even more important to understand if you're trying to make distinctions, as the

drafters are, between exchange subsidies, CHIP, and Medicaid when, in fact, those differences as they exist at the state level may not be so clear and may be pretty messy and those differences certainly in the application process are not obvious or straightforward. So I think those are points that I think can be really helpful.

And then, of course, from the standpoint of, you know, a particular family in a particular state may be getting help through subsidies versus Medicaid, depending on whether the state expanded or Medicaid versus CHIP. So I think helping the drafters understand the lines or the messiness or the degree to which it varies by state I think can help them take that into consideration.

With respect to the impact on providers and the safety net, I think that we can point out it may be bigger than they think, depending on the results of this -- you know, what happens with this chilling effect. I'm a little worried that it seems like our evidence for that is all based on concerns expressed by others -- but I think we should let them express those concerns for themselves -- or kind of secondary research. So I would like maybe you to help us see what we have originally to contribute about

being able to project potential impacts that maybe are different than the drafters assumed on the basis of -- I know Anne makes fun of me when I talk about modeling, just meaning any kind of research or scientific analysis or data-based analysis. You know, whether we have anything that we could be doing there that really kind of contributes a view of that that is different than others are helpful.

So let me open it up for any other commentary, additional commentary from the Commissioners. Kit.

COMMISSIONER GORTON: So I would just add to your list, when you were talking about, you know, any open door, in some states having insurance is still mandatory, Massachusetts being among them.

CHAIR THOMPSON: Yep.

COMMISSIONER GORTON: So it's not optional for people. So I think that's worth -- and the other question that came to me as I was reading through this is: What about HIPAA? This is protected information. Your insurance coverage is protected. We don't disclose to people whose members of what or whatever else. So wouldn't we have to give DHS authority to draw down, particularly in

these circumstances where not everybody has -- no? Am I completely off --

CHAIR THOMPSON: I think we're just all quizzically wondering whether that's true or not true.

COMMISSIONER GORTON: It's not public information whether --

CHAIR THOMPSON: But government agencies exchange data all the time. But that's -- I mean, we can take a note.

COMMISSIONER GORTON: I was just asking a question. I don't know what the answer is.

MS. HEBERLEIN: So it's my understanding that the rules of data sharing are different depending upon the public program, and I think for like TANF, the state agencies can share what they know about immigration status. In the ACA there was some pretty clear rules that when you're applying for coverage, that information is only to be used for applying for coverage and not to be used for other purposes. And there was some guidance that came out that was talking about immigration being one of those purposes. So --

CHAIR THOMPSON: So how do the drafters respond -

- you know, handle that? Or did they know about that?

MS. HEBERLEIN: I don't know if they know about that or not. They don't really talk about how they will track whether or not somebody has used a public benefit, and so that's one of the questions, I think, that is sort of outstanding.

CHAIR THOMPSON: All right. Well, that is an example of, I think, applying some expertise -- thank you, Kit -- to contribute some considerations.

Toby and then Alan.

COMMISSIONER DOUGLAS: So agree that we should lay out some of the impacts that you put in here. I have more of a technical question around the exclusions for school-based Medicaid services as well as Medicaid benefits provided under the Individuals with Disabilities Education Act. I'm struggling how that's possible given that they're going to be -- the way the schools get -- you get what I -- so if you can just answer that.

[Laughter.]

MS. HEBERLEIN: Yes, I was totally following where you were going.

COMMISSIONER DOUGLAS: Okay.

MS. HEBERLEIN: So, yes, in order to be reimbursed for services provided in a school, a child would need to be Medicaid enrolled, and the school would need to be a Medicaid provider.

IDEA services are slightly different. If the child is Medicaid enrolled and the family gives them permission to bill, then they can -- I'm looking at Joanne because we talked about this -- then they can get Medicaid funds for those IDEA services. If not, states do --

COMMISSIONER DOUGLAS: But they still have to be on Medicaid.

MS. HEBERLEIN: Yes, and states -- but states do have some limited IDEA grant funds that they could use to provide some of those services if the child is not Medicaid enrolled or if the child's parent doesn't give them permission to bill Medicaid for those services.

COMMISSIONER DOUGLAS: But now --

CHAIR THOMPSON: But you're making --

COMMISSIONER DOUGLAS: Both of those just should be -- they don't make sense. I mean, you can't do it.

[Laughter.]

COMMISSIONER DOUGLAS: They're putting in an

exemption that doesn't even exist.

CHAIR THOMPSON: Right. So, Toby, you're saying it's defined as a Medicaid service, but Medicaid services are only available to Medicaid enrollees.

COMMISSIONER DOUGLAS: And once they're on Medicaid, then all the other doctors are going to play into account. They can't go --

CHAIR THOMPSON: Right, so how is the state -- even if a state and a beneficiary were trying to work together to segment those services, how would they be segmented --

COMMISSIONER DOUGLAS: Because there would still be a capitated payment going to the managed care plan, so there would be -- they would be a public charge under this definition for other reasons.

CHAIR THOMPSON: Okay, yeah. So I think the -- that's a good point. The viability of making some of the distinctions in the context of how Medicaid pays for and delivers services is, you know, more challenging and potentially problematic than perhaps they understand. Emergency Medicaid, though, is a little bit different, right? Because that is really handled separately, right?

Okay. So we should maybe -- if we see some, like that could work, but this is not going to be -- you know, would require a complete redesign of something.

Alan?

COMMISSIONER WEIL: Just to add to Toby's absurdity, does that mean if you --

COMMISSIONER DOUGLAS: I didn't say that.

[Laughter.]

COMMISSIONER WEIL: To the absurdity that Toby brought to light. Does that mean if you get care at a DSH hospital, you're a public charge --

I guess I want to push a little beyond -- I agree that it's an opportunity to educate. I'm not sure how much that is going to matter, but I am struck by the intersection with eligibility, not just eligibility standards, but eligibility processes. And I'm trying to step back a little bit from where we are today and think about the history of the program.

We've made major efforts in outsourcing eligibility, and that means having clarity of message by people who have to understand the rules which, as you note, are not state-consistent. And I think it puts the whole

eligibility enterprise at risk if the implications of someone becoming eligible are unknown to the person who's, in theory, helping you become eligible.

That feels to me different from sort of the technical question of differences. That how can I look out -- as you say, you come asking for help, and in order for me to know whether or not it's helpful, I have to now know something that I don't know. That's spread through lots of places. This is not just a form you fill out.

I also think about how much over the years -- and, again, we don't say it so much these days -- there's been attention to outreach, and not just in a state where you're legally required to have coverage, but that great effort has gone into consistent messages of the value of coverage.

I'm trying to stay in our lane here -- right? -- which is hard.

CHAIR THOMPSON: We're all trying to thread this needle. Yeah.

COMMISSIONER WEIL: But the lane is what we've been trying to do to try to run the program efficiently and have it meet the need it's supposed to meet does require

some ability to be unambiguous about the value of the program from the enrollee's perspective.

The moment you pull that away -- again, I'm trying to stay in the lane of not whether it's good policy or not, but it prevents Medicaid from doing something it's spent a whole lot of years trying to figure out how to do. And that feels to me like that's in our lane.

CHAIR THOMPSON: I agree. I'm completely comfortable with that. I think that is absolutely a true statement, which is that -- and this Commission has weighed in, for example, on the value of getting to as complete children's coverage as possible and took that into consideration when we made recommendations around CHIP, and a lot of that has to do with the idea that the coverage really matters and making it easy for families to come in and enroll matters and making sure they understand why they should be insured matters.

I think that you're right. Not only does it in some ways rub up against that, it also puts kind of a big question mark in that equation for both the beneficiary and for anybody assisting them, including a provider, who might be seeing them for the first time and trying to get them,

help them be enrolled in Medicaid, and is that really a good thing for them or not a good thing for them?

So I think it's worth pointing out that that tension exists. Again, I don't know that we can weigh it, but we can certainly talk about that aspect of this in the context of this rule. I'm totally comfortable with that.

Chuck and then Stacey.

COMMISSIONER MILLIGAN: A couple of questions, and I'll do some comments.

Martha, forgive me if I missed this, but I'm looking at the language that says "is likely at any time to become a public charge," and what do we know about how that will be predicted?

MS. HEBERLEIN: Under the current rule and the proposed rule, it is a prospective looking forward.

COMMISSIONER MILLIGAN: Right.

MS. HEBERLEIN: But the way they describe how they weigh these sort of -- the financial, the education, all the different criteria that they're going to be looking at is they say, "Well, your past experience can be predictive of your future experience." So we will look at your past receipt of Medicaid as predictive of whether or

not you will receive it in the future.

COMMISSIONER MILLIGAN: So it's not going to take into account whether you've never received Medicaid, and you might be predicted to receive Medicaid? It's only based retrospectively on whether you have, in fact?

MS. HEBERLEIN: So there's other criteria that may come into play. There's things like health status that they're going to be looking at. There's age.

COMMISSIONER MILLIGAN: Okay.

MS. HEBERLEIN: So it's possible that some of the predictive use of Medicaid in the future might come in under those factors.

COMMISSIONER MILLIGAN: Poverty level health status, whatever.

MS. HEBERLEIN: Yeah.

COMMISSIONER MILLIGAN: My second question is -- and, Penny, I want to go back to kind of your comment when you kicked us off about how the eligibility is determined and exchanges and all that stuff.

There still are a lot of community organizations, including FQHCs, that do a lot of work with and are authorized to help do Medicaid determinations. Does the

proposed rule put any onus on them to do anything with any information they may have received from a potential applicant, like reporting duties or anything?

MS. HEBERLEIN: It doesn't talk about, the reporting, where they're going to get the data on public benefit use.

COMMISSIONER MILLIGAN: Okay.

MS. HEBERLEIN: It also doesn't talk, to the earlier point about, the onus of the providers or the enrollment as sisters would be to educate the applicants about the potential effects of application based on -- for their immigration status.

COMMISSIONER MILLIGAN: I want to make, I think, two comments.

One is I was the Medicaid director in New Mexico when both welfare reform was passed and CHIP was created, and New Mexico was a border state. The chilling effect was real. There was a lot of concern about applying for CHIP for kids when CHIP was created in the late '90s and whether the parents who might not themselves be citizens would end up finding themselves deported because of all of that kind of stuff.

So, at the time, we worked closely with HHS, and at the time, it was Immigration and Naturalization Services to get official letters that this is not going to create a deportation risk, and we had to disseminate it a lot through our promotoras and FQHCs and others who were working with families at the border because there was a lot of concern, in spite of insurance mandates, people will not pursue it if they're going to worry about deportation. It is anecdotal, but it is real, both.

The other comment, I guess, I want to make is not to go down the whole DSH rabbit hole again, but there's going to be a disparate impact across states by this kind of thing because of border states being different than non-border states in terms of just prevalence of how this could play out and the uncompensated care implications of some of that. So not to kind of reopen the whole DSH discussion, I do think that to the extent that this rule, if finalized in the form shaping up, it could lead to a state variation of uncompensated care itself created out of this rule that has disparate impacts on states. So I'll just leave it at that.

MS. HEBERLEIN: Yeah, good point.

CHAIR THOMPSON: Stacey, were you --

VICE CHAIR LAMPKIN: I just want to weigh in, acknowledging the trickiness of finding the right place here. I want to weigh in, in support of not only commenting, but having our comments go beyond basic educational -- I think there is a value judgment that we can make based on the value of the coverage itself, based on the concept of a responsibility related to an early warning sign of an access problem.

I think we can say here based on historical analog, there does appear to be likelihood of an access problem beyond what the drafters of the regulation have estimated, and we think the coverage has value. So we have a concern about that.

CHAIR THOMPSON: Right. But what we can't do is weigh that against the other values that might be outside of our purview.

We can express a view about this is moving in the direction opposite from the one that -- or may introduce impacts opposite from ones that the Commission has been trying to work on. So it works at cross-purposes to things that we have been trying to promote.

That doesn't mean that that is what rules the day versus other considerations that we cannot, by virtue of our mandate, take into --

VICE CHAIR LAMPKIN: Agree, and we can acknowledge that in our letter, with still expressing those.

CHAIR THOMPSON: Right, right.

Let me just pause here for a moment and see if we have some comments from the public that we should take before summing up and proposing a final direction for our **comments.**

PUBLIC COMMENT

* MS. HARO: Good afternoon. Is this on?

CHAIR THOMPSON: Yes, indeed.

MS. HARO: Hi. I'm Tamar Magarik Haro. I work for the American Academy of Pediatrics. The American Academy of Pediatrics is a nonprofit professional association and comprises 67,000 pediatricians.

As this entity well knows, we've reached historic levels of uninsurance among children. This proposed rule threatens the health and well-being of millions of children. By some estimates, in addition to the ones that

were presented today, we've seen an estimate as high as 9 million children could be affected by the proposal.

In our view, the proposed rule presents immigrant families with an impossible choice. You either keep your family healthy, but risk being separated or forego vital services like preventive care and food assistance, so your family can remain together in the U.S.

The magnitude here cannot be understated. One in four children in the U.S. lives in an immigrant family, meaning that either the child or at least one parent is foreign-born.

As this distinguished group knows very well, children enrolled in Medicaid are twice as likely to have routine checkups and vaccinations as uninsured children. Loss of that coverage would have high short-term costs.

Children with Medicaid are more likely to receive proper treatment for chronic conditions and less likely to have avoidable hospitalizations. Parents and children's health are inextricably linked, and children do better when their parents are mentally and physically healthy. Parents who are enrolled in health insurance are much more likely to have children who are insured as well.

Research demonstrates that safety net programs like SNAP and Medicaid have short- and long-term health benefits and are crucial levers to reducing intergenerational transmission of poverty.

The Academy is not alone in expressing its opposition to this proposed rule. We are joined by virtually every major medical provider association in the U.S.

I'll just quote at the publication of the proposed rule, the American Academy of Pediatrics joined by the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American Psychiatric Association all issued a statement in opposition to the proposed rule.

In our statement, we said, "Many of the patients served by our members almost certainly will avoid needed care from their trusted providers, jeopardizing their own health and that of their communities.

As a result, the proposed regulation not only threatens our patients' health, but as this deferred care leads to more complex medical and public health challenges

will also significantly increase cost to the health care system and to U.S. taxpayers."

For all these reasons, as well as many of the ones that were expressed by the members of the Commission, we very much hope that you will submit comments. In our view, we believe that this proposed rule should be rescinded.

CHAIR THOMPSON: Thank you.

MR. ZAMAN: Good afternoon. I'm Shahid Zaman, and I'm here on behalf of America's Essential Hospitals. We represent hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Our more than 325-member hospitals manage to provide high-quality care while operating on narrow financial margins, half of those of other hospitals across the nation.

The average essential hospital provides over $70 million in uncompensated care every year, which is nearly nine times the amount of the national average.

We appreciate the Commission's discussion of the Department of Homeland Security's public charge proposal, and we have serious concerns about the proposal and the implications for Medicaid beneficiaries and hospitals

serving large Medicaid populations.

The proposal would jeopardize the health of millions of lawfully present individuals and threatens the stability of hospitals and the communities they serve. By creating a strong disincentive to seek care, the rule would force people to forego medical visits and medications until they are sicker and costlier to treat.

The rule would also deter those who are eligible for and legally entitled to Medicaid from enrolling in Medicaid or would encourage those who are already enrolled in Medicaid to disenroll from the program. It would drive higher levels of uncompensated care, particularly for those hospitals that can least sustain these increased costs.

The proposal would reduce access to vital health care services and lead to worse health outcomes.

In addition to the financial and health care repercussions of the rule, as the Commission touched upon, it would also impose excessive compliance burdens on hospitals and state Medicaid agencies that are involved in eligibility determinations.

We at America's Essential Hospitals are analyzing the impact of the rule and will be providing written

comments to the Department of Homeland Security.

We also urge MACPAC to continue to analyze the proposal and the devastating consequences it will have for vulnerable populations and the Medicaid program.

We do hope that the Commission decides to comment and that will provide comments to DHS on the impact to hospitals and other safety net providers.

Thank you, and we look forward to the Commission's work on this issue.

MR. D'AVANZO: Hi. Good afternoon. My name is Ben D'Avanzo. I am senior policy analyst at the Asian-Pacific Islander American Health Forum. We are a national advocacy organization that works with Asian-Pacific Islander populations around the country advocating for their good health.

We work with a lot of direct service organizations that have already seen the impact of just the rumors about this rule, hearing stories about families asking to disenroll from Medicaid, refusing to use electronic medical services, missing doctors' appointments and the like.

We're very concerned about the disproportionate

impact that this rule would have on communities of color and especially on Asian-American-Pacific Islander populations. For example, 30 percent of green cards go to people coming from Asian-Pacific Islander countries, and there was a reference to the test that people would be subject to, to determine if they would be likely to be a public charge. That includes an income test that would be negatively weighted if you make under 125 percent of poverty in addition to having potential health conditions that could impact your ability to work or having to prove that you could pay for unsubsidized health insurance, among other factors, including limited English proficiency. We find those very, very worrying and disturbing.

We really want to highlight that there is a wide variety of organizations that have spoken out against this rule in addition to providers and hospitals. We have seen plans, immigration groups, Members of Congress, all express concern, a lot because of that lesson of the 1990s, which many of our organizations experienced.

You saw in the 1990s, after welfare reform, certain efforts by the predecessor to DHS to target women coming in with small children to the U.S., who had left and

are coming back, who are immigrants, asking who had paid for their birth of those children, and if Medicaid had paid for their birth, Medi-Cal in most cases -- this was happening a lot in California -- then those women would be potentially denied entry for being a public charge.

This led to a lot of women disenrolling from Medicaid or people disenrolling from Medicaid, and even after the rule was clarified in 1999, because of efforts of a lot of those organizations, there was still mass confusion and concern.

The proposed rule places the burden on immigrants. So if you look at the draft form, there is a requirement to list benefits that they have applied for or received in the past. The instructions for the rule just say Medicaid. So in states where Medicaid has a different name, then there is going to be a lot of confusion, or someone just may not know if they are on Medicaid or not.

We are definitely concerned about any provision or any implementation that would involve using Medicaid agencies or other entities of having to report data, and the mere existence of this rule has led to people being very concerned about that possibility in both the agencies

themselves as well as the organizations and the clients that many of our partners work with.

So we definitely encourage you all as Commissioners to weigh in. This is clearly not a rule drafted by people who understand what the health impacts are going to be and it drastically underestimates the chilling effect, and we think that there is a strong role for you all to play in both educating, but also in making it clear that this is not a rule that can be fixed. This is a rule that is unworkable in any form.

Thank you.

CHAIR THOMPSON: Thank you.

MS. WHITENER: Hello again. Kelly Whitener from Georgetown Center for Children and Families.

I think in addition to the comments that others have raised, I hope that you will comment. I hope that you will raise the big-picture issues about what this type of rule would mean for children and their families in terms of access to coverage, but I also think you have a pretty unique voice in how you can weigh in on the operational challenges of this rule and not just the challenge to try to make it work, if that's what you were wanting to do, but

the costs that would come with that and how it would run counter to the statutory mandates directing Medicaid and directing the Affordable Care Act coverage.

So if you think about things like single streamlined application that some of you raised in your own comments, how does that work in the context of this proposed rule, and how should HHS and DHS sort of duke that out? And I think you guys have an ability to shed a lot of light on some of those issues that other groups are not as well positioned to do.

So I hope you include that in your comments as well.

CHAIR THOMPSON: Okay.

Any other comments from the public?

[No response.]

CHAIR THOMPSON: Any additional reactions or discussion from the Commissioner?

[No response.]

CHAIR THOMPSON: I did want to pick up on a couple of the points made by the public commenters. I do think that to the extent there is something that people are required to disclose on their applications that say

Medicaid, I think that's very consistent with, you know, discussions that we've had about the way in which Medicaid is understood in states, or branded in states, and the extent to which people may not realize because they're in private plans or they're in different systems of care that they are on Medicaid, and if that produces legal risk for the person if they don't properly report that then I think we need to signal to people that it may not be a reasonable expectation for people to have that information.

I do think this issue about the need for HHS and DHS to have pretty intense conversations around some of these policies' intention and operational implications is also a point that we can make and suggest.

So I think that we want to go ahead and make the comments that we've discussed in the areas that you've laid out here, Martha, for us, in addition to the other additional texture and points that we've made in this Commissioner conversation. It's due December 10th so we won't have an opportunity to discuss this again before our next public meeting, so we'll leave it to the staff to construct that language and we'll have a review by Stacey and I of that information before it's submitted for public

comment.

Good. Any other comments or questions?

MS. VISHNEVSKY: My name is Debbie. I'm a member of the team at the Children's Dental Health Project. I also wanted to highlight that -- so while our focus is oral health, we like to look at oral health under the umbrella of how we make it possible for families to improve their access to success in general and how that impacts the overall health as well as the oral health of their children.

I think something else that's also worth mentioning, and I think could fall in the lines of this kind of more specific road that understandably MACPAC needs to focus on, when you make it more difficult for parents to engage in these programs we make it harder for them to get out of these kinds of more challenging circumstances. Without access to oral health, without access to even basic health care programs and preventative care, it's harder for them to keep jobs. It's harder for them to improve the overall kind of circumstances that their family is functioning, and which also impacts the health of their children. And I think that's of vital importance when

we're looking at not just how these programs function but also the individuals who are benefitting from these programs. So I think that's also worth considering in your comments.

CHAIR THOMPSON: Thank you. I think there is something that maybe just sets the stage here about, you know, we talk about state options for coverage and why states have exercised the options that they have and why they consider coverage for these populations important and why states cover parents and caretakers as well as children and how those related to one another. I think there are some points there that we should make in the introduction, just to kind of set the stage for some of the things that we may want to go on and talk about.

Martha.

COMMISSIONER CARTER: Commissioner.

CHAIR THOMPSON: Commissioner Martha.

COMMISSIONER CARTER: I think as you draft a letter I wanted to urge that you word it as strongly as you can, comfortably. I think the potential for damage is great here, and walking the line of what's possible, I would urge you to be as strong as possible.

CHAIR THOMPSON: Okay. Thank you.

Okay. Thank you very much, Martha. Thank you to the public. Great comments. Appreciate you sharing those with us.

MANDATED REPORT: MEDICAID IN PUERTO RICO

* CHAIR THOMPSON: Okay. Next up we're going to talk about Medicaid in Puerto Rico and we're going to hear form Kacey on this subject. Welcome back, Kacey, and Stacey is going to take the gavel up at the Chair's table.

MS. BUDERI: Okay. So earlier today you heard me talk about Arkansas and this afternoon I will be talking about the Medicaid program in a different part of the United States, Puerto Rico. And this is a topic that the Commission has not discussed before. However, previous work on this has been descriptive. It includes a fact sheet outlining the key features of Puerto Rico's Medicaid program, which was last updated in February of this year, and a slide deck with information on Medicaid financing and spending, published in September of 2017.

This presentation today is in response to a congressional request. I'm going to start by reviewing the language from that request. Then I'll provide some

background Puerto Rico and some of the economic and fiscal issues it is experiencing. I'll go on to discuss the key features of the Medicaid program in Puerto Rico; which differs in many ways from state Medicaid programs. I'll describe the Medicaid financing and spending situation in Puerto Rico, which, as you may know, is a major and ongoing challenge for the program and the territory because of the capped allotment financing structure it has. And I'll talk about what we know about access to care and quality of care for Puerto Ricans and describe some of the challenges there. I'll conclude with some possible next steps and then turn it over to you for discussion.

In the report accompanying the fiscal year 2019 Labor, Health and Human Services and Education Funding Bill, the House Committee on Appropriations requested that MACPAC examine possible options for ensuring long-term sustainable access to care for Medicaid beneficiaries in Puerto Rico. This request has no specific due date.

Before I get into some of the issues, I want to note that available data on the issues facing Puerto Rico are limited. Most of the data we do have are from before Hurricane Maria hit last September, so we're limited in the

information we can provide you today. This presentation draws on the data and information that is publicly available as well as conversations we've had with current and former CMS officials and others knowledgeable about the situation in Puerto Rico.

As a little bit of background, Puerto Rico is the oldest and most populous U.S. territory. It has a population of about 3.3 million. Individuals residing in Puerto Rico are U.S. citizens so they can travel to or move to a U.S. state without restriction. While they're residing Puerto Rico they are eligible for many federal programs, including Medicare, Medicaid and CHIP, but they are excluded from others, such as Supplemental Security Income. They generally do not pay federal income tax although they do pay most other taxes, including Medicare tax. They have no voting representation in Congress and they cannot vote in presidential elections.

As most of us know, Puerto Rico's economy and infrastructure were damaged significantly by Hurricane Maria, and that damage and recovery have been really in focus. But Puerto Rico has long experienced economic challenges, particularly going back the last two decades.

Over this time, Puerto Rico has experienced a major economic decline, with an 8 percent decrease in real GDP from 2005 to 2015. Over the same time period there was a 9 percent decrease in labor force participation and a 7 percent decrease in population, and this population loss was driven by outmigration of educated and working adults.

Puerto Rico also has a substantial debt burden, amounting to $74 billion in bond debt and nearly $50 billion in unfunded pension obligations. To try to address this, Congress passed the Puerto Rico Oversight Management and Economic Stability Act in June 2016. It's also called PROMESA, which, among other things, created a fiscal control board with discretion over the territory's budget and the power to force debt restructuring.

Key economic indicators are significantly worse for families in Puerto Rico than in the United States overall. The unemployment rate is more than twice as high and median income is half the median income in the U.S. overall. Health indicators are more mixed. For example, life expectancy is similar but self-reported health is significantly worse.

The uninsured rate is actually lower in Puerto

Rico than it is in the United States. The portion covered by Medicaid is a lot higher. In 2017, for example, it was about 47 percent versus 21 percent. Puerto Rico also has a larger share of people covered by Medicare and a much smaller share covered by private health insurance.

Given the high Medicaid coverage rate, Medicaid is a central part of the safety net and health care system in Puerto Rico. In 2017, it covered over 1.5 million people, including about 250,000 dually eligible individuals, and about 90,000 Medicaid expansion CHIP enrollees. For the purposes of Medicaid, Puerto Rico is considered a state unless otherwise indicated, so many of the Medicaid rules apply to Puerto Rico. However, the program differs in substantial ways from Medicaid programs in the states, and these differences are primarily related to eligibility, covered benefits, and the financing structure.

So in terms of eligibility, Puerto Rico is exempt from requirements to extend poverty-related eligibility to children, pregnant women, and qualified Medicare beneficiaries, and it uses the local poverty level to set eligibility. So it currently covers individuals with up to

133 percent of the Puerto Rico poverty level, which is approximately equivalent to just 40 percent of the federal poverty level. And then because individuals residing in Puerto Rico are not eligible for SSI, coverage for aged, blind, and disabled individuals is provided through the medically needy option.

Puerto Rico also differs from state Medicaid programs with regard to benefits offered. Puerto Rico is technically required to cover all of Medicaid's 17 mandatory benefits but it is currently only providing 10 of them. The specific list is in your materials but notably nursing facility services and non-emergency medical transportation are not covered, and Puerto Rico has cited funding and infrastructure barriers to providing these services. Several optional benefits are provided, including dental care and prescription drugs, and then cost-sharing assistance is provided for dually eligible individuals.

Like many states, Puerto Rico uses a managed care delivery system. Beneficiaries are assigned to a plan based on their geographic region. Several concerns have been raised with the current structure, including Puerto

Rico's capacity to conduct adequate oversight of the plans; access concerns, particularly with regard to long wait times for needed specialist care, which I'll talk a bit more about later; and then concerns about the adequacy of capitation rates, which have historically been quite low.

Puerto Rico is actually in the process of transitioning to a new managed care system that they hope will address some of these problems, and under the new plan the MCOs will provide island-wide coverage rather than coverage to their assigned geographic region, and they'll need to compete for enrollees who will now be able to choose their plan. And this is scheduled to take effect November 1, so next week, but it hasn't been signed off on by CMS yet.

Getting to the financing piece, which is central to many of the issues in Puerto Rico's Medicaid program and larger health system, the financing structure for Puerto Rico's Medicaid program differs in two really key ways from the states. First, while Puerto Rico has an FMAP, like the states, it's set in statute at 55 percent. If it were determined using the same formula used for states, which is based on per capita income, we would expect to see it at

the maximum allowable rate of 83 percent.

And so Puerto Rico draws down federal dollars at this matching rate, but unlike the states it can only do so up to an annual cap, and this cap, which is sometimes referred to as the 1108 cap, was set in 1968 and grows with the medical component of the CPI-U. It does not have a relationship to the cost of the program. For example, in FY 2018, it was $357.8 million, though actual total expenditures were projected at $2.62 billion.

There are some exceptions to this cap. For example, spending to set up a Medicaid fraud control unit, spending to provide prescription drug cost-sharing to dually eligible individuals does not apply to the cap. However, in general, Puerto Rico cannot access federal dollars beyond this cap.

These two financing pieces, the statutory FMAP and the cap, have led to a substantially lower level of federal financing than would otherwise be the case, and at times the federal contribution has dropped to below 20 percent of total costs. And so to make up for this, Puerto Rico has historically had to take on a much greater share of program costs than would be expected of a state, or even

their 55 percent FMAP would indicate. And one way they have financed this is by issuing bonds which have contributed substantially to Puerto Rico's debt crisis.

In recent years, Congress has provided additional federal funds on a temporary basis to help make up for this funding shortfall. The ACA provided a $6.3 billion allotment in federal Medicaid funds, available to be drawn down any time between July of 2011 and September of 2019, and that's on top of the annual capped amount.

Puerto Rico exhausted these funds faster than anticipated and were close to running out by the time Hurricane Maria struck last fall. So in response to that funding running out, and Hurricane Maria, Congress provided $4.8 billion through the Bipartisan Budget Act of 2018, and that's available for FYs 2018 and 2019. $3.6 billion of this was guaranteed and $1.2 billion was conditional on Puerto Rico meeting milestones related to T-MSIS reporting and the establishment of a MFCU, which they have met, so they'll be getting that $1.2 billion. And Congress also provided a 100 percent federal matching rate for these funds, so Puerto Rico does not need to put up a non-federal share.

This graph shows spending and sources of funds for FYs 2011 through 2017, and it illustrates the degree to which Puerto Rico has depended on these supplemental funds that Congress has provided. And you can see that the dark blue area at the bottom is the amount Puerto Rico receives from their annual capped allotment, so that's the 1108 cap, and then the medium blue shade almost entirely reflects use of these temporary additional funds, which for this time period were provided by the ACA, but for 2018 and 2019 would be from the BBA.

And so because of that BBA funding for FYs 2018 and 2019, Puerto Rico will actually have more federal funding available than it is projecting to spend, but any additional funds left over will expire on September 30, 2019. After this point there will be no source of federal funds beyond the annual allotment, which we expect to be approximately $375 million.

This situation, when additional federal funds expire or are exhausted, is often referred to as Puerto Rico's Medicaid fiscal cliff. If Congress does provide additional funding but does not extend the 100 percent matching rate there's also the question of whether Puerto

Rico would be able to contribute its share of the program cost, given its current fiscal challenges.

There is some research around what might happen if Congress fails to provide Puerto Rico with extra funds. When the ACA funds were about to be depleted before the BBA was passed, the Assistant Secretary for Planning and Evaluation at HHS estimated that 900,000 people could lose coverage, and it's not clear what safety net services would be available to individuals who become uninsured in such a scenario.

Some studies have also looked at the effect of people migrating from Puerto Rico to a mainland state and found that federal Medicaid costs increase. For example, a 2017 report found that at the current migration rates federal Medicaid spending would increase by $9.7 billion over the next 10 years and state spending would increase by $6.1 billion. However, these estimates do not account for a potentially faster rate of migration following the hurricane, and some reports indicate the rate has more than doubled.

So obviously these financing challenges have been and will continue to be an issue for Medicaid in Puerto

Rico. But Puerto Rico is also facing challenges related to access to care. Puerto Ricans receive care in many of the same ways that people on the Mainland do, so in physician's offices, hospitals, health center. Notably there is no long-term care sector in Puerto Rico, which is why the benefits aren't provided under Medicaid.

The most recently available data on access in Puerto Rico, which is generally from 2014, indicates that Puerto Ricans at that time had better access to many types of health care than Americans overall, after controlling for economic and demographic factors. However, health care facility capacity and provider availability varied widely across the island. For example, there were more primary care physicians per 100,000 people than in the U.S. overall, but 32 of Puerto Rico's 78 municipalities were designed as primary care shortage areas.

Also, access to certain types of specialty care was extremely limited. For example, there were few intensive care unit beds and just one trauma center in 2015. There were also few physicians practicing in certain specialties. Examples include emergency room physicians, obstetricians, gynecologists, pediatricians, oncologists,

and more, and long wait times for many types of specialist care have been reported as a persistent issue.

Of particular concern following the hurricane has been the need for behavioral health services, and we don't have any data on unmet needs for these services but there have been many anecdotal and media reports about this issue. And then underlining these access challenges has been a declining provider workforce due to outmigration, and this is a trend prior to the hurricane, and by all anecdotal accounts has gotten a lot worse following the hurricane. One reason is that salaries are low compared to the relatively high cost of living in Puerto Rico, and they are also low compared to salaries on the mainland. So to help address this issue, Puerto Rico increased Medicaid payment rates to 100 percent of the 2018 Medicare rates earlier this year, but the effects are unclear so far.

So in terms of quality of care, the data that is available show a mixed picture when compared to the U.S. overall. For example, in 2014, Puerto Ricans were more likely to have a usual source of care than people in the U.S. overall. However, they were less likely to receive certain types of screenings, for example, for colorectal

cancer or Pap tests, and they also had lower vaccination rates among children.

And while some of the access issues may contribute to this, some reports have also cited infrastructure-related challenges, particularly a lack of key equipment in hospitals and slow adoption of health information technology as barriers to improving quality of care.

So again, because of the gaps in available data, we are limited in the information we can provide you with, and it may be hard for the Commission to make specific recommendations at this stage. However, we anticipate that we could include a descriptive chapter in the March 2019 report to Congress that could serve as our response to the Committee request, and if there are specific areas that you'd like us to look further into we can do that, and we can also convene a panel at an upcoming meeting if you'd like to hear more from people knowledgeable about the situation in Puerto Rico.

So I'll stop there.

VICE CHAIR LAMPKIN: Thank you, Kacey, very much, and you've done a really good job in describing what can be

known at this time and the complexity of the current situation and the complexity of the potential options that could be considered to improve. It's really sobering information. And you've also, I think, very usefully laid out some important context in history about how the Medicaid financing has -- the interplay with that and the economic situation and the way that's developed. That's great context.

Before we open it to Commissioner discussion and questions, though, I have a question for you about maybe do we have -- about the congressional request itself and the kind of context there. It sounds like from your planning that the fiscal cliff is expected when current extra funding runs out next September. And so is this request in the context of that and Congress is looking for guidance and input kind of leading into that -- how to address that fiscal cliff? Or do we have additional context around that?

EXECUTIVE DIRECTOR SCHWARTZ: As Kacey stated, there's no date specified, and it really was only a one-line request. You know, I think we've heard from the authorizers that they're interested in this topic, too.

But, you know, it -- we can provide information. They'll be getting information from, obviously, the Commonwealth itself.

VICE CHAIR LAMPKIN: Okay, thanks. That was helpful. It's sort of vague language in the original

EXECUTIVE DIRECTOR SCHWARTZ: Yes, extremely vague.

VICE CHAIR LAMPKIN: Okay. All right. With that great background, Kit, can you kick us off?

COMMISSIONER GORTON: Sure. Thanks, Kacey. Lovely job. So I'm going to start with two things.

First, a lot of emphasis in the media coverage and even in the request from the authorizers about the uniqueness of the Puerto Rico situation, and I don't want to diminish that in any way. But I do think we have some places that we might be able to learn things, and I fear that with the typhoon bearing down on Guam, we may have other opportunities to learn as well. So worth thinking about things in a broader context perhaps.

So the first thing I would like to suggest is that we -- one of the things we might be able to offer folks is a look back at what happened in places like New

Orleans after Katrina, where we saw many of the same phenomenon going on -- huge outmigration -- and one of the things, I think, that the folks in New Orleans taught us is that they needed not to plan for the future of New Orleans to be the past of New Orleans. They needed to plan for New Orleans to be the New Orleans it was going to be. So they shrunk the school district by some outstanding proportion because all the students moved out.

On the health care side, I had the opportunity to be working in a health plan serving Louisiana after the storm, and one of the things that happened is that people with complex medical conditions often got moved out because they couldn't be cared for in Louisiana during the -- and Fred probably has a point of view about this as well -- because they couldn't be cared for. The infrastructure had just disappeared. Many of those people didn't go home, and so one of the things to think about is where -- and as we think about Puerto Rico, where are these people potentially landing? Historically there's a huge relationship between Puerto Rico and New York City, and people go back and forth. There's easy travel back and forth and, you know, so it will be interesting to see whether the folks in New

York are experiencing children with complex medical conditions appearing there that hadn't been there before, that kind of thing. And, again, this data may not be knowable. These may just be questions that we can ask at this point. But it seems to me that we can look at some of the experiences from Katrina. There may be other examples that come to other people's minds, and then use that to potentially inform what are we trying to accomplish with the rehabilitation of Puerto Rico and what did people manage well in New Orleans in terms of getting professionals to come back and other things like that, what didn't go so well. So there may be some lessons to be learned from that that we can help assemble from the health care and Medicaid front.

Which takes me to the second point that I want to make, the descriptive data that you provided us was fascinating, but, you know, given the short period of time you had to pull it together, most of it was sort of comparisons with national means. And Puerto Rico wasn't anywhere near the national mean for most things going into the storm, and the likelihood that they get anywhere near the national mean after the storm is pretty remote, at

least in the near term. And so I wonder whether it's appropriate to use other comparators. Should we be looking at the lowest quintile of states to see how they were performing against them before the storm and how they do after? And I'm not suggesting we pay no attention to national means, but we want to be realistic in terms of what are we going to be able to accomplish, and I think we want to have a realistic sense of how bad it is. Once the data starts coming out, you know, are they functioning within the lowest quintile of states or not? And if they're not, how far below are they that? That to me seems to be a more reasonable comparison than just the U.S. mean. And the other slice of that is the raw data. Puerto Rico is predominantly Hispanic and Spanish-speaking, so if you are going to norm their health outcomes, you need to norm them -- now, it's the majority language in Puerto Rico, but still, the genetic base and the cultural background and other things match Hispanic populations on the mainland. And so I think that it's worth thinking about, okay, how do Puerto Ricans in Puerto Rico measure up to Puerto Ricans in New York? How do they measure up to Puerto Ricans in the southern border states? So I just wanted to think about

other ways that we could illuminate the situation there to make sure that we had sort of the full context in order to help people assess what fixes they wanted to put in place.

VICE CHAIR LAMPKIN: Thanks, Kit. So maybe we go Brian and then we have Kisha, Sheldon, and Fred.

COMMISSIONER BURWELL: So great job, Kacey. My takeaway from reading this chapter is that things are really messed up in Puerto Rico, and, you know, there's various contradictory things. It's obviously a program that Congress intentionally underfunded, you know, 55 percent FMAP, it's got a cap on it. You know, there was like a conscious policy decision that we're not going to give Puerto Rico the same federal share that we give other states, and somehow, you know, it's going to be a lower quality health care system than we have elsewhere, and that seems to have been the case.

And in response, Puerto Rico seems to have been very kind of -- it's not really complying in terms of running it like a Medicaid program. You know, we only cover 10 out of 17 mandatory benefits, et cetera. But then there's all these infusions of federal money lately that actually has greatly increased the federal investment to

the point where in the current fiscal year they have more money than they will spend. It just makes no sense to me.

So, I mean, is this a Medicaid program that we really shouldn't call a Medicaid program? It's capped. It's not an entitlement. Is there a need to just break it off from Medicaid and have it as a block-granted federal health care, you know, program and just run it in accordance that's appropriate for the circumstances of Puerto Rico? I don't know. I mean, that's a pretty extreme recommendation for us to make in a report, but it just seems to be a situation that requires fairly radical policy intervention rather than, you know, somehow trying to make this -- continue to run this as somewhat of -- somewhat like a Medicaid program.

COMMISSIONER DAVIS: I think I would love to hear from a panel of folks in Puerto Rico to get the on-the-ground perspective, especially because there's so much difficulty in getting the data and to hear more about the before and after. What we have is really from 2014, and so to really get that perspective of what things are like on the ground, and I would love to hear that perspective.

I think the other thing that strikes me is just

the inconsistencies in primary care, and we know that a strong primary care workforce would be helpful, and there's inconsistencies in how it's paid for. So are there opportunities where Medicaid can be helpful in that in terms of thinking about different ways to pay for primary care that would encourage providers to come back? And also thinking about how Medicaid pays for telemedicine, and is that a way to account for some of the brain drain issues that they're facing in terms of specialists and ways that they can collaborate more with folks in the mainland to kind of make up for some of those deficits?

VICE CHAIR LAMPKIN: Thanks. Sheldon, then Fred, then Chuck.

COMMISSIONER RETCHIN: I thought that was a really terrific report, Kacey, and certainly spurs for me a lot of thoughtful interest in Puerto Rico. I do think Brian's comment, though, is like an above-the-fold comment, a headline, that it's Puerto Rico, I would conclude, is really messed up.

So here's where I -- first of all, I wanted to ask a question that was puzzling in the report, that the primary care density is actually higher in Puerto Rico than

in the mainland?

MS. BUDERI: The report that I saw said that there are more -- at that time -- I think it was 2014 -- there were more primary care physicians per 100,000 people than in the U.S. overall.

COMMISSIONER RETCHIN: Which I think must be indicative of just a different approach to care, and maybe the emphasis of Medicaid managed care in particular, but, still, that they're able to hold on -- or were before the storm. But let's be clear. The storm simply precipitated the trend that's been there for more than a decade, and physicians are leaving the island at four times the rate of the population. But I wonder -- and so that's of great concern to me in terms of the long-term viability. And I wonder, in a report for the issue of long-term sustainability, is this sort of PAYGO, that with the people moving off the island, if they're -- and we don't know. Are they leaving the island because they're going to leave anyway and it's been accelerated by the storm? Or is the concern over the health care infrastructure, does it have any influence in that? Because we're not going to fix the island. We're not going to fix the debt, which is

essentially is a municipal default. But do you have any anecdotal information on that?

MS. BUDERI: I've seen reports that indicate that, in addition to the lower relative salaries, physicians have cited contributors like there being a lack of good training opportunities in Puerto Rico and a lack of key equipment in health facilities, for example, MRIs, lack of good hospital infrastructure. But I don't really have anything firm to share with you on that.

COMMISSIONER RETCHIN: Okay.

VICE CHAIR LAMPKIN: Fred.

COMMISSIONER CERISE: Well, I have seen some of this before, the post Katrina experience, and, you know, it does lend itself to big ideas, as Brian said, you know, do you want to just redo the whole thing, because here's your opportunity. And that same discussion went around New Orleans after Katrina. I can remember the Secretary spent a fair amount of time down there and said, you know, talk to Medicare, Medicaid, CDC, HRSA, SAMHSA, get everybody in the room and just make it up and do it differently. You know, we're going to make this the model for redesign, but nobody could -- everybody had rules to follow, and so you

made some incremental changes, you did a little bit better in primary care as things grew back. But it looks the same as the rest of the health care world.

And so, you know, it is a time to reflect and say, all right, if you are putting the pieces back together, if you can invest heavily in this, do you want to be more intentional about how you do it? And so I do think it's worth thinking about.

Some of the differences, you know, when the population goes away and you don't have the people to practice on and health care providers go away at an accelerated rate as well, in New Orleans you had big hospital systems that supported the -- somebody had to float the provider system while you didn't have patients to pay for it, and so some of the big systems supported their specialists so that they wouldn't leave. But they were essentially paying for them, but they weren't doing work. And so there was a buffer that was built in there that you don't have in Puerto Rico, and so I have no doubt they're feeling it more acutely there.

You know, everybody has talked about sort of the problems that existed there before that no doubt have been

exacerbated. You can't help thinking of if almost half the population is covered through Medicaid, to Brian's comment, you're halfway there already. And if you're going to be able to support some of the physicians staying, some of the other health care providers staying, you know, it probably should involve some intentionality, you know, if you're going to invest and you really can't expect systems to be healthy if they don't know what's coming after next year, when you see the graphs of, you know, a fix this year, a fix this year, a fix the next year, and for these public institutions to be able to build something sustainable, they have to know something's going to be there beyond two years from now. And so it seems like, you know, if you really wanted to dive into this, you would be more intentional about a design and then make a multi-year commitment to stay the course.

VICE CHAIR LAMPKIN: Thanks, Fred. Chuck.

COMMISSIONER MILLIGAN: I definitely wanted to hear from Fred before I commented. I continue to have tremendous respect, Fred, for what you did to lead things in Louisiana after Katrina.

I have a question or two, Kacey, and then a

couple of comments. You did a great job laying out the background. Puerto Rico is one of five territories. Do we know contextually whether the other territories have similar challenges with capped allotments and FMAP limits and structural challenges? Do we know about the Virgin Islands and Guam and Mariana and American Samoa? Do we know much about is Puerto Rico representative of that situation for territories pre-Maria or is it anomalous? Do we know?

MS. BUDERI: Puerto Rico was definitely the territory of the five that struggled the most with their capped allotment and where that had been set. All of the other territories also have a capped allotment. We actually have fact sheets on each of the other territories' Medicaid programs, and they all work a little bit differently. But in terms of their underlying fiscal situations and their access issues and their broader health systems, I don't really know much about them.

EXECUTIVE DIRECTOR SCHWARTZ: There are a couple of differences I think we can point to. First of all, Puerto Rico swamps the other territories in terms of its size. So it's much bigger in terms of people. It's much

bigger in terms of geographic area. And I believe, although I haven't read the fact sheets recently. First of all, U.S. Virgin Islands is obviously extremely affected by the hurricane. The Pacific territories don't have as much of a private health system infrastructure. There's usually a couple large hospitals or health centers, which is where everybody gets their care. And I believe in Guam, basically everyone is just assumed to be eligible for Medicaid. So Puerto Rico -- sort of stands somewhere between those territories and what you would see in a state on the mainland.

MS. BUDERI: I would certainly say that the Medicaid program in Puerto Rico and the U.S. Virgin Islands are the most similar ones to the state Medicaid programs. The Pacific territories work, as Anne was saying, much differently. For example, in American Samoa -- you said Guam, but it's American Samoa. They get basically -- you know, everyone gets provided health care when they go to the public hospital, and then Medicaid actually is just a financing stream, and they calculate how much money based on -- I mean, it's in the fact sheet. But it's based on the percentage of people under 200 percent of the poverty

level, I believe.

COMMISSIONER BURWELL: I just want to say I had a nice conversation with the Medicaid director in Guam a couple weeks ago, and she cited herself as the only Medicaid director that was also on Medicaid.

[Laughter.]

COMMISSIONER MILLIGAN: So when we report to Congress, I think just a little bit of like a text box about some of this would be good context.

I guess my main comment is my assumption is that the reason Puerto Rico is called out for purposes of our involvement is the hurricane, and so I think we need to determine kind of like the focus of how we handle this request is Puerto Rico as a territory versus Puerto Rico as devastated by a hurricane. And I think the latter needs to be kind of the through thesis of how we approach this, and -- because I assume that that's why Congress -- I'm making an assumption here, but I think that that's why Congress was looking for some information from us. And so I think wherever we take this -- and, you know, I defer to the group as a whole -- I think it has to be in the context of what's the right federal response in the face of a

devastating natural disaster that a community can't itself recover from without some support. So I think -- as opposed to the implications of being a territory. So that would be my suggestion.

CHAIR THOMPSON: Okay. I'll just jump in. I think the -- given Anne's answer to what do we know about what people were really looking for from us, I'm not sure that it's hurricane as much as it is the expiration of some funding authorities and trying to get ready for that. So I think we should figure that out -- I mean, I think if we can validate any of that and get a sense about what people are really looking for from a focus perspective, because I think you're quite right, those are --

COMMISSIONER MILLIGAN: But, Penny, if -- that's one of the reasons I started by asking about the other territories. I don't know if they're in the same debt situation. I don't know if they're upside down in terms of how to finance Medicaid.

CHAIR THOMPSON: Oh, yes. I'm not suggesting that it's about territorial financing as opposed to Puerto Rico versus Puerto Rico with a hurricane.

COMMISSIONER MILLIGAN: Okay. I just -- whatever

context we can lend then to the situation going into the hurricane as distinct maybe from the other -- I think we need to contextualize -- and that's why I started with my question that way.

MS. BUDERI: If it's helpful for you, Chuck, I can tell you that Puerto Rico is the only one that was bumping up against that ACA allotment. I think Northern Mariana Islands was getting close, but Puerto Rico was the only one that was actually -- the other territories are still using their ACA allotments. Puerto Rico is the one that ran out and is constantly bumping up again that extra funding.

EXECUTIVE DIRECTOR SCHWARTZ: I think those are great points, Chuck, and I think that we can provide some context for that. I think in some ways the issues are sort of inextricable because you have to think about post-hurricane but also what what was the thing that you were building on. And if that has got its own set of concerns, you have to acknowledge those as well.

I'm not sure we will get more guidance, but I think your point is well taken, and I think it's one that's not terribly difficult for us to incorporate in our

narrative.

VICE CHAIR LAMPKIN: So Melanie and then Bill.

COMMISSIONER BELLA: So this is just since I still can claim being new kind of question.

Will we talk to Medicaid officials in Puerto Rico and talk to them about where are you struggling, how can we be helpful, like what kind of issues are you facing? Can we actually try to be helpful from their perspective in writing this report?

MS. BUDERI: Yes. So I'm in touch with them, and I've talked to them several times. And I can continue to do that.

EXECUTIVE DIRECTOR SCHWARTZ: And maybe that's who we can also invite to come for a panel or you to hear. I mean, there are a number of perspectives that we could hear from Puerto Rico, and honestly, based on the number of convenings here in Washington, I think they tend to be happy to come if we can make the scheduling work for them.

So we could hear from the health plan. We could hear from the Medicaid director. We could hear from the primary care association. We can figure it out.

COMMISSIONER MILLIGAN: And we can hear from our

former MACPAC Commissioner who is doing a lot of work there too.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. And we've been talking to him too.

COMMISSIONER SCANLON: I am going to go back a little bit to where Chuck was.

I think it's important to understand the broad context and not just in the health care system and in territories, but the context of the economies. I had this sense that the economy of Puerto Rico has been different. This is conjecture, maybe, not based on a lot of strong evidence on my part, but that they had probably a stronger manufacturing sector that have some of the other territories that maybe rely more on tourism sort of as a principal economic driver.

The question of sort of all of their debt, I mean, how much of that is a function of their tax policies?

I want us not to be naïve when we draw conclusions from their situation, but I also want us to investigate all of these things because we obviously can influence all of these things. The fact is their situation today is their situation today. What the historical causes

are may be important, and they may not, and we're not going to change them. We need to at least spend some of our time thinking about sort of how they might fit.

VICE CHAIR LAMPKIN: Darin, and then we'll wrap.

COMMISSIONER GORDON: I'd just say with the exception that some of those underlying structural issues that you're talking about -- sustainability, understanding what those have been -- could lend insight to how we come up with a sustainable path forward.

VICE CHAIR LAMPKIN: So this has been good. I want to just quickly summarize. It seems to me like we have a couple of different areas here.

One is some other kinds of comparatives or relevant information, post-Katrina, Louisiana, that we could bring into a descriptive Puerto Rico chapter for context and comparison, and then another is potentially bringing a panel to talk to us and maybe even get into some solutions or options that telemedicine or other technology -- are they relying on medical tourism, Miami, in some kind of context, something there to help us understand what they're doing in the short term and what they think some of

the longer-term options might be.

Is that --

COMMISSIONER BURWELL: Our mandate is to evaluate long-term sustainable access, but I'm sure if people from Puerto Rico come, they're all going to be about the cliff in 2020. So it's definitely a short-term/long-term problem, and how do we want to approach each of those?

CHAIR THOMPSON: And maybe that's a specific charge to the panel to try to elucidate and segment those two questions. That could be, I think, very interesting to talk about the shorter versus the longer term.

Thanks, Kacey, so much.

VICE CHAIR LAMPKIN: Yeah. Thanks.

CHAIR THOMPSON: Okay. Great.

We had a public break scheduled -- a public comment and break. Let me go ahead and ask for public comment on this discussion, but we're not going to take a break. We're just going to keep going and finish out the day since we started a little bit late.

PUBLIC COMMENT

* MS. HALL: Hi. Cornelia Hall from the Kaiser Family Foundation.

We've been also tracking a lot of the work, the hurricane recovery in Puerto Rico and the Virgin Islands, and involved with a couple of people here on that, so thanks to Kacey and everyone for this report.

I just wanted to underline a few things that you said based on our research and our conversations with territory health officials, providers, Medicaid directors.

It all comes back to the FMAP and the cap for them. So, as you all were just saying, I think if you heard from them, there's just a lot of concern and anxiety about the fiscal cliff, and as they are recovering from the hurricane, implementing these managed care changes, and also anticipating that fiscal cliff, there just are a lot of strains on the Medicaid program in those two territories right now. So I just wanted to highlight and underscore the FMAP as the primary concern that we've been hearing over and over again from them.

Also, two points that Kacey made that I just wanted to underscore, due to the out-migration that began before the hurricanes, the population that's left in Puerto Rico is disproportionately older and sicker and disabled and has lost a lot of social supports that they had, family

members and other people, before the hurricanes. So that might also be something to consider when looking long term at the fixes to the Medicaid program there.

Then also as you mentioned, it's a regional issue. In Puerto Rico especially, we've heard areas around San Juan and other metropolitan areas have recovered more quickly than the mountainous regions and the two offshore islands of Vieques and Culebra, which are both still off the grid and are going to be using generators for the next two years. And the population on Vieques is still going to the mainland for dialysis.

The same thing in the Virgin Island and St. Croix. I think they still don't have full dialysis services there. So there's still a lot of recovery still going on over a year after the hurricanes.

Then just to put in a quick plug in response to a couple of questions, we released our 50-state budget survey today, but we also, for the first time, have a supplement with the territories. We've interviewed all of the five territory Medicaid directors. That's going to be coming out in a couple weeks, and it might be useful for all of you in your work ahead.

So thanks so much.

CHAIR THOMPSON: Thank you.

Did you bring us copies of the 50-state surveys? We're all eager --

MS. HALL: Yes. It's just up the street.

[Laughter.]

CHAIR THOMPSON: Thank you very much for those comments.

Okay. We'll move on now to Chris Park, and we're going to talk about Medicaid drug coverage and talk about the results of some work that you've been doing, Chris, on comparison of Part D and commercial plan formularies and Medicaid drug coverage.

COMPARISON OF MEDICAID DRUG COVERAGE TO MEDICARE PART D AND COMMERCIAL PLANS

* MR. PARK: Thank you, Penny.

I'll just let people move around a little bit.

Okay. At our December meeting last year, we heard from our panel that while Medicaid has had success in managing utilization for many traditional drug classes, the available management tools are less effective in containing costs and utilization for high-cost specialty drugs.

Some states have expressed interest in adopting commercial-style formulary tools. In particular, Massachusetts recently submitted a Section 1115 waiver amendment seeking to adopt a closed formulary. This request was ultimately denied by CMS.

The Commission has expressed interest in better understanding how Medicaid's management of drugs compares to other payers and whether states need more tools to help them control drug spending.

MACPAC has contracted with IMPAQ International to conduct an analysis to compare Medicaid coverage of drugs under a preferred drug list to Medicare Part D and commercial plan formularies. This project assesses whether Medicaid offers broader coverage than other payers and how this coverage and other restrictions vary across payers.

This presentation will present findings from the first phase of this project. The second phase, which will link the formulary information that we found in this initial phase to actual utilization, and that is scheduled to be completed next spring.

So, as a quick refresher, payers have different requirements regarding drug coverage. For Medicaid, the

program must generally cover all drugs as part of the rebate program.

For Part D, plans must offer at least two chemically distinct drugs in each category and class. For six protected classes, they must offer all or substantially all of the drugs offered in those classes.

For commercial plans that are required to provide essential health benefits, plans must cover the greater of either one drug in every class or the same number of drugs in a class as the benchmark plan.

For other commercial payers, such as self-insured employer-sponsored plans, there are very few requirements for those plans.

For this analysis, we selected a sample of 261 brand and generic drugs that represented a broad selection of both high-cost drugs and highly utilized drugs across 29 drug classes.

We ultimately determined coverage if either the brand or generic version was covered. So this ultimately meant that our comparison was made on 130 unique chemical products selected in our sample.

We obtained formulary and plan information from

Managed Market Insight and Technology and used data from December 2017.

For each plan and payer, we looked at the number of covered drugs as the way to measure the breadth of coverage and the availability of drugs for each payer. We also looked at the number of unrestricted drugs; that is, drugs that did not have any utilization management restriction, such as prior authorization, step therapy, or quantity limits.

A low number of unrestricted drugs in a class would indicate that the plan formulary had a high level of utilization management.

For both the number of covered drugs and unrestricted drugs, we also identified formularies that were considered outliers with extremely low coverage for each drug class.

For the outlier analysis, we calculated a threshold that represented the minimum number of covered or unrestricted drugs required to be on a formulary to not be considered an outlier. For example, there were 13 drugs in the second-generation atypical anti-psychotics class, and we calculated an outlier threshold of 10. So that means if

a formulary offered fewer than 10 drugs in that class, it would be considered extremely low, and that formulary was flagged as an outlier.

For each class, we calculated thresholds at the national level as well as state-specific thresholds, and in addition, for each payer, we identified the percent of covered lives that were affected by a formulary that was considered an outlier in at least one drug class.

So, generally speaking, Medicaid formularies had broader coverage than Medicaid Part D or commercial plans. The median number of covered drugs for Medicaid formularies was greater than or equal to Medicare and commercial formularies in all of the drug classes reviewed, and Medicaid had a higher median number of covered drugs in eight classes, as seen on this slide, than both commercial and Medicare Part D plans.

Based on the outlier test, Medicaid also appeared to offer broader coverage for both the national and state threshold standards. Medicaid had about 18 percent of covered lives affected by a drug coverage outlier at the national level compared to about 50 percent of lives for both Medicare and commercial payers.

And if we use the state-level test, it also shows a similar relationship with Medicaid having a fewer percent of covered lives affected.

In addition, as shown in the dotted circle, we looked at Medicaid fee-for-service compared to Medicaid managed care, and Medicaid fee-for-service had a lower percentage of lives affected by drug coverage outliers than managed care.

Part of this difference between fee-for-service and managed care may be due to how certain drugs are covered by managed care. Certain drugs may be carved out of the managed care plans, and we're not exactly sure how these drugs may be represented in the data. Certain drugs may not appear on a managed care formulary, but the beneficiary may ultimately be getting coverage on the fee-for-service side for those drugs.

While Medicaid generally covered more drugs, they may place more restrictions on drugs. In general, most of the formularies across all three payers had a low number of unrestricted drugs in each class, indicating that most formularies put some level of restriction on almost all of the drugs in the class.

Medicaid generally had a similar number of unrestricted drugs as the other two payers; however, Medicaid did have a lower median number of unrestricted drugs than commercial and Medicare plans in six classes, as shown on this slide here.

Based on the outlier analysis on utilization management restrictions, we kind of see a mixed picture. Based on the national standards, Medicaid had more lives affected by outliers; however, as I mentioned earlier, most formularies across all three payers included restrictions for all or mostly all of the drugs in a class.

At the national level, we are only able to calculate an outlier threshold for one class, which was the immune suppressant DMARDs, and so what you see here is really kind of reflecting differences in utilization management for that one particular class.

When we looked at the state-level thresholds, we were able to calculate thresholds for nine classes, and here, you can see that Medicaid is somewhat in between Medicare and commercial. It's higher than commercial and lower than Medicare.

Again, looking at the difference between fee-for-

service and managed care, it appears fee-for-service has fewer, has lower restrictions than managed care and kind of similar to what we saw for the drug coverage.

So for the takeaways, broadly speaking, these results show that Medicaid programs generally have the ability to manage prescription drugs in a similar manner as other payers. While Medicaid generally covers more drugs than other payers, it tends to place restrictions on these drugs and use utilization management tools at a similar or higher rate than other payers.

However, the differences in coverage for specific classes or specific drugs across payers may be larger. For example, 84 percent of Medicaid lives have formulary coverage for Exondys 51, which is a drug used to treat Duchenne muscular dystrophy, compared to 61 percent of commercial lives.

This analysis also has a few limitations. The comparison does not take into account any differences in formulary tiering or cost sharing. So while copayments of Medicaid are nominal, Part D and commercial plans can use differences in cost sharing as another tool to manage use and direct beneficiary behavior toward preferred drugs.

Also, this analysis is a point-in-time analysis. So coverage differences across payers may be larger at certain points in time, particularly during the first few months when a new drug comes to market, as Medicaid generally must cover these drugs immediately, while commercial payers and Part D have around like 180 days to make a coverage decision.

Additionally, it's important to note that this first phase of this analysis does not look at how these coverage policies actually tie to utilization in these classes. Even though payers may have prior authorization requirements for the same drug, this does not mean that those requirements have the same level of restrictiveness or lead to a similar distribution of drugs within a particular class. We have begun work on second phase of this project to link to formulary policies to utilization to better understand the practical effects of these policies.

We believe this additional information will be helpful to you in assessing Medicaid's ability to manage utilization of spending and whether additional tools are needed.

We would appreciate any feedback you have on this first phase of analysis. As I mentioned, we're starting the second phase right now, so we do have an opportunity to take into account some of your comments and may be able to address some of those in the second phase.

CHAIR THOMPSON: Thank you, Chris.

A couple of questions. I'm sorry. I didn't see this addressed in the paper, and I don't think you covered this, but when we talk about utilization management, can we remind ourselves what we're talking about?

MR. PARK: Sure. That is prior authorization, which would require the beneficiary to get approval from either the state Medicaid program or the managed care plan in order to fulfill the prescription, step therapy which may require the use of a lower cost or generic version first before having permission to try a higher cost or a non-preferred brand, as well as quantity limits, which may restrict how many prescriptions or fills or pills you may get at any particular time.

CHAIR THOMPSON: And are those the three UM approaches states use, or are there more but --

MR. PARK: Those are kind of the three.

CHAIR THOMPSON: Those are the three most common?

MR. PARK: Yeah. Those are the three kind of broad categories. When people talk about UM, that's kind of what they're talking about.

CHAIR THOMPSON: So we're not including lock-in?

MR. PARK: That's correct -- well, in the sense that, potentially if the lock-in is listed as a prior authorization requirement, then potentially we would be picking --

CHAIR THOMPSON: On the sense that you could go to another pharmacy, but you have to get prior approval for another pharmacy?

MR. PARK: Right.

CHAIR THOMPSON: Okay. And so the next phase, will we be able to distinguish among those categories when we do the next phase of analysis, and do you think that matters?

MR. PARK: In terms of whether a drug had to be authorized or --

CHAIR THOMPSON: A quantity limit versus a prior authorization --

MR. PARK: I don't think we'll be able to

determine that from the data that we'll be using to determine the utilization because I don't think we'll have all of the claim information as to whether it had some kind of edit or anything like that. So I don't think we would be able to determine like a prior authorization had a greater effect on utilization than step therapy or anything to that degree or whether that particular person was affected by those tools.

CHAIR THOMPSON: Okay. So I'm going to ask a broad question that you probably cannot answer, but I'll ask it, anyway, which is -- so I look at this and say, well, is it better to have broad coverage and a lot of utilization management, or is it better to have narrow coverage and less utilization management? And better from the standpoint of cost control, better from the standpoint of access and meeting the needs of beneficiaries. Any thoughts on that?

MR. PARK: Well --

CHAIR THOMPSON: Are we going to be able to pick that apart in any fashion?

MR. PARK: I think, you know, this is one area where it may ultimately depend on the drug and the class as

to whether that's a better situation. Certainly if it's very few drugs in a class and they're kind of significantly different in terms of, you know, the treatment for various conditions or like the severity of various conditions, it may be better to have broader access to all of the various treatments available in that particular class. Even though they're restricted, you still have a chance to get the drug that may be best for you.

In a more traditional class, such as, you know, the cholesterol drugs like statins where there may not be significant differences among all the choices right now, it may not matter as much as to whether it was unrestricted coverage -- you know, it may be better to have unrestricted coverage, you just get whatever you want, versus having a selection of ten of the ten versus seven of the ten. So I think it kind of depends probably on the situation as to whether one of those would be preferable or not.

CHAIR THOMPSON: And the nature of these interventions matters, does it not? So I could see how some of these interventions may be more science and data-based and others not when it comes to especially UM practices and maybe even coverage decisions, but how are we

going to think about that? You know, there's certain -- what you have to do to meet the requirements of a prior authorization program can vary substantially from one payer to another payer or one state to another state, and yet they would all show up in our analysis as, well, there's prior authorization, but the experience of providers and beneficiaries and the degree to which people -- I mean, we're going to get at some of that kind of by proxy by looking at utilization, you think?

MR. PARK: I think broadly speaking we'll use utilization as a bit of a proxy to try to get a sense of how restrictiveness --

CHAIR THOMPSON: How wide or narrow --

MR. PARK: -- or, you know, how much it kind of shifted behavior. We do have some information within the formulary data about particular notes in terms of, you know, what was required for prior authorization. We attempted to look at some of that for a couple of drugs, and one thing that was difficult is, you know, across several thousands of formularies, how do you kind of summarize that information and classify it as to, you know, make a good comparison and that was requiring a lot of

work. So, you know, we kind of limited it to a couple of drugs, but we could certainly, if there are drugs that the Commission is particularly interested in, try to explore a little bit more on a qualitative level as to what the restrictiveness was for those particular drugs.

CHAIR THOMPSON: Yeah, I think it's possible that we could find ourselves wanting to dive in a little bit just because at a high level I think it becomes very interesting, but it becomes very hard to interpret because there is so much meaningful variation in those terms and whether or not we're really comparing apples to apples or apples to oranges.

And I just want to remind ourselves, we got into this because we were asking ourselves whether the requirements of the drug rebate program created constraints on states that were significantly different than other payers were experiencing. And am I right in concluding the results of this analysis is they may be going at it slightly differently, but they're still actively managing -- they're effectively actively managing their formularies in the way that other --

MR. PARK: Yeah, I think it's a bit of a mixed

picture, and I think it kind of reflects the statements we heard in our December panel that for a lot of the drugs and a lot of the classes, Medicaid does a pretty good job, and they're kind of managing the use similar to other payers. Some of these more specialty classes where maybe it's like the first drug in the class or it's a unique situation where they don't have as many tools because they can't, you know, exclude coverage and if there's a question as to whether this drug is truly effective, you know, Medicaid programs may want to be more restrictive or not cover the drug, where commercial plans can actually do so, you know, Medicaid doesn't have quite the flexibility to do so.

CHAIR THOMPSON: It's just it's easier in those situations to just exclude it as opposed to develop a UM approach to managing it.

MR. PARK: Right. So I think, you know, there are probably a few cases where Medicaid may be significantly limited compared to commercial plans, but kind of broadly speaking, across everything, they're not, you know, that different.

CHAIR THOMPSON: Okay. Thank you.

All right. So I saw Kit, Brian, Chuck, Toby.

Fred, did I see you? No? I imagined that. Okay. Kit.

COMMISSIONER GORTON: So with regards to the questions you asked, Penny, I think it's also important to keep in mind what the cost of the drug is, right? Because there's a return on investment in utilization management. It costs money to hire nurses and doctors and pharmacists and coders and all the others to set these things up. And so you pick your place. But we know that Medicaid programs find their administrative budgets often capped, so that's a level of less flexibility -- if I'm running a Medicaid program, I simply can only act so fast and I can only do so many and I can only grow my budget so much. That's part of why the hepatitis C drugs were so devastating. You just couldn't put enough in place fast enough, and the no 180 days. So I think you need to think about that.

The gloss I want to give on what Chris said about the three major categories of UM, there are degrees, right? So there are flashing yellow lights, and there are speed humps, and there are stop signs, and there are red lights, and then there are, you know, barricades. And where you throw those things up depends on how common the condition is, how expensive the drug is. Exondys is a great example;

Kalydeco for kids with cystic fibrosis. And so all that, I think -- and Chris will correct me if I'm wrong, but I think at the level of administrative claims data for the pharmacy benefit, we're going to have trouble getting to the level of clarity, and I think part of what you did in the Phase 1 study was say we can't study all drugs all the time. I think what you may want to do is focus down even further, at least on some classes of drugs, and on periods of time, right?

So we now have enough history with hepatitis C that you can look at what happened when Sovaldi came on the market -- well, you can look at what the baseline was when we were dealing with PEG Interferon and that whole mess. And then Sovaldi comes on the market, and you can look at what happens there and compare that to commercial versus the plans.

And then the other drugs come on the market, and things all shift, right? So there were huge changes in the formularies over the course of 18 to 24 months, and I think that may illuminate where the commercial payers, where the Part D carriers had flexibility that the Medicaid programs didn't have. Ultimately, I think the Medicaid programs

probably for most things in most places get to the same place. Pediatric drugs, particularly in the post-OBRA '89 environment of expanded EPSDT, a little trickier because it's sort of hard to say what's medically necessary and what's not. And to the extent you have drugs like Kalydeco which are pointed at a pediatric population, that can be an issue. But I think that -- DMARD is another good example. You know, I think if we hone in on a couple three sets of very expensive drugs that came out and launched over time -- statins isn't going to tell you anything. If you could go back and look at statins in the '80s, that might tell you something because that's when they -- but now they're all pretty cheap, and they all work pretty much the same. And so I wouldn't invest a whole lot of energy trying to tease that out. But I would think about emerging therapy, because I think from my point of view, emerging therapy is one of the places where Medicaid has the least cover.

CHAIR THOMPSON: Where a commercial payer may wait.

COMMISSIONER GORTON: Yes.

CHAIR THOMPSON: But Medicaid cannot.

COMMISSIONER GORTON: Medicaid cannot.

CHAIR THOMPSON: And then may not have the evidence and the capacity to get on top of it from --

COMMISSIONER GORTON: Correct. And if you're in a state that has a big, you know, biopharma sector or that's a big part of the economy, there are political pressures that come in there. And so, you know, I think we might learn more by focusing on a couple of case studies -- not that we shouldn't do the other work because I think the other work is important. But I think where you're going to really tease out the substantive difference is at the points of inflection.

CHAIR THOMPSON: Thank you, Kit. Brian, Chuck, Toby, Sheldon.

COMMISSIONER BURWELL: So my question was pretty much the same as Penny's in terms of broader kind of where are we going from a policy perspective on this. The way I'm hearing this analysis is that we're looking at the Faustian deal between Medicaid and drug companies around the drug rebate that you have to cover all drugs on your formularies. And this analysis looked at that and said, okay, what is the implication of that deal relative to commercial and Medicare? And if I'm right, it's not a

whole lot because Medicaid can use these other tools to control --

MR. PARK: That's correct. I think, you know, in terms of the ability to put prior authorization and other tools -- and use other tools, it's not that different. How those ultimately play out as to whether, you know, those prior authorizations are --

COMMISSIONER BURWELL: Yeah, this is just a process analysis. So Phase 2 is going to be what's the actual impact on utilization.

MR. PARK: Right

COMMISSIONER BURWELL: So do we feel that we have the ability to actually look at that.

MR. PARK: Yes, we're going to --

COMMISSIONER BURWELL: Like because it's specific to the specific utilization management control that is utilized, right?

MR. PARK: Right. We won't be able to, like, assign, you know, quantify the effect of prior authorization per se, but I think we will be able to say, you know, for this drug in this class, like all three payers kind of assigned some utilization management to it,

you know, what was the effect? Did that really drive behavior? Did the utilization of that drug for Medicaid differ from commercial or Part D?

COMMISSIONER BURWELL: You're going to control for population type?

MR. PARK: We will have some medical information to a certain extent because we are looking -- we will look at specific classes that does control a little bit for differences in populations in that they all have a particular condition that needs to be treated with this drug, so to treat that particular condition, are they using a more expensive drug or, you know, less expensive drug? Are they using generics versus brand? Things like that. You know, we'll be able to look at that. But we won't necessarily be able to necessarily tease apart all the comorbidities that may be affecting these beneficiaries.

COMMISSIONER BURWELL: Okay. Thanks.

CHAIR THOMPSON: We'll let the adjective "Faustian" pass without comment. Chuck.

COMMISSIONER MILLIGAN: Nice job, Chris. One quick comment, and then I think I want to sort of suggest two areas of focus.

It seems to me that one other distinction that could exist but my gut is it's not is how easy or hard the exceptions process is for patients to get some drug that isn't preferred or on a formulary. But to me that's kind of a minor aside.

I think in terms of advancing our work about the Medicaid Drug Rebate Act, to me there are two things I would really want to see some focus on, one of which several folks have touched on is this 180-day. I do think if we want to weigh in on that more strongly than we have historically, we need to understand better the distinction between Medicaid, Medicare, and commercial about what happens in that 180 days, you know, what the implications to patients, all of that kind of stuff. So I think that that -- and I think Darin, as I recall one of the meetings, was, you know, that states should have the opportunity to evaluate is this new drug to market an improvement of what's already available or not if there's a big price distinction and all that stuff. So I think the 180-day thing and what those other payers do during that period and how does that change a Medicaid decision versus theirs, I think that's an important area for us to get some focus on.

And to me, the second one -- and I don't think we've mentioned it in this discussion so far -- is whether the drug rebate or the rebate provisions of Medicaid distort what drugs end up on the PDL because of how the rebate provisions interplay with the drugs that are on the PDL. And so in the determination for commercial and Medicare about -- or MCOs, what drugs end up in a formulary or preferred and how the rebates are obtained by those other purchasers versus Medicaid, and Medicaid kind of working inside of the Drug Rebate Act, does it -- does the rebate piece of it influence the development of the PDL and how is that distorted or not? Because I think that there's -- that will then have implications to whether and how we weigh in on the rebate rules themselves that Rick has walked us through a few times.

CHAIR THOMPSON: Good. Thank you, Chuck. Toby.

COMMISSIONER DOUGLAS: Yeah, my question is on this last piece on just utilization and then the net of rebates, bringing the full picture. And I think this gets to that question I asked before, so I don't know where we are on getting to it, but I don't know how we really truly understand the implications of the different formularies

without taking in what's the net cost compared to what Medicare or others -- because you could have more on the PDL, and some might be more expensive, but in sum, given the flexibility that Medicaid has and the rebates, that it's still better off.

MR. PARK: Right. Yes, that's certainly going to be a limitation of this analysis in that we won't be able to get drug-specific rebate information to really understand what the --

COMMISSIONER DOUGLAS: Where are we on -- was that -- what happened?

MR. PARK: There was some language introduced that would give both MedPAC and MACPAC access to the rebate information, but that hasn't passed, you know, yet. So it's still to be determined when and whether we'll ever get access to that specific information.

COMMISSIONER DOUGLAS: Thank you.

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: I would just -- I am interested -- and maybe it was Kit that just raised it about looking backwards on the hepatitis C dissemination of treatment, just to point out, though, that even those that

we've become comfortable with that have no price differentials like statins, the PCSK9 new drug is -- whereas, the statins are an average of about $1,100 a year, it costs $14,000 a year and is enjoying -- or experiencing an increase in prescription rates. I'd be interested in knowing actually. I assume that because it had rapid approval that it's also on the -- part of the Medicaid?

MR. PARK: Yeah, Medicaid does have to cover the PCSK9 inhibitors. I'm pretty sure we included that as part of our analysis, but I don't know the specifics on that right now. In terms of doing kind of like a time series for a particular drug or class, that is something we're thinking about for Phase 2 to see if we can identify a few drugs that maybe were introduced in the market within the time period of data that we have. Unfortunately, we don't have formulary information that goes back far enough on, like, the hepatitis C drugs, but there may be a few particular drugs or classes where, you know, a new drug was introduced in 2017 where we have our data that we can kind of look for a few months after it came to market to see kind of what the formulary differences and utilization differences were.

CHAIR THOMPSON: Any other Commissioner comments?

[No response.]

CHAIR THOMPSON: Chris, this is excellent work. I think the challenge is, you know, we do have some practical limitations on data and you can't analyze the world for us, and so I think I hear, you know, to the extent that we can dive down into some things and really sort of pull apart what's inside of what we're looking at, I think that would be helpful.

MR. PARK: Okay.

CHAIR THOMPSON: And let me ask for public comments.

EXECUTIVE DIRECTOR SCHWARTZ: Can I just add something quickly? I just wanted to mention for Commissioners, particularly since the issue around the grace period came up, we haven't abandoned that. We're just sort of putting it on a hold for a while. We've got a whole bunch of things all kind of going at the same time that are not all coming back to you tied up with a bow. We are going to have a panel at the December meeting with some state folks talking about some innovative things that they're doing. And so, you know, at some point in the

future, all these pieces will start coming back together again. Right now we're very much exploring a lot of different ways --

CHAIR THOMPSON: Surrounding the issue.

EXECUTIVE DIRECTOR SCHWARTZ: Yes, we are overwhelming you with random things.

CHAIR THOMPSON: Good. Thank you for that.

Any public comments?

PUBLIC COMMENT

* [No response.]

CHAIR THOMPSON: And thank you, Chris, and that's the end of our agenda today, and we will see everyone tomorrow. We're adjourned.

* [Whereupon, at 3:42 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, October 26, 2018.]

PUBLIC MEETING

Ronald Reagan Building and International Trade Center
The Horizon Ballroom
1300 Pennsylvania Avenue NW
Washington, D.C. 20004

Friday, October 26, 2018
9:05 a.m.

COMMISSIONERS PRESENT:

PENNY THOMPSON, MPA, Chair
STACEY LAMPKIN, FSA, MAAA, MPA, Vice Chair
MELANIE BELLA, MBA
BRIAN BURWELL
MARTHA CARTER, DHSc, MBA, APRN, CNM
FRED CERISE, MD, MPH
KISHA DAVIS, MD, MPH
TOBY DOUGLAS, MPP, MPH
LEANNA GEORGE
DARIN GORDON
CHRISTOPHER GORTON, MD, MHSA
CHARLES MILLIGAN, JD, MPH
SHELDON RETCHIN, MD, MSPH
WILLIAM SCANLON, PhD
ALAN WEIL, JD, MPP
KATHY WENO, DDS, JD

ANNE L. SCHWARTZ, PhD, Executive Director

AGENDA PAGE

P R O C E E D I N G S

[9:05 a.m.]

CHAIR THOMPSON: Okay. We'll go ahead and close the doors and get started. Good morning, everyone, and welcome to day two of our October meeting. We're very pleased to kick off this morning with a couple of very experienced and insightful state leaders who will help us understand the world that we're living in today with respect to dual eligibles.

So I'm going to let Kirstin kick us off and do the introductions.

STATE EXPERIENCES INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES: PANEL ON STATE PERSPECTIVES

* MS. BLOM: Thank you, Penny. Good morning, Commissioners.

So our first couple of sessions today are going to be focused on integrating Medicare and Medicaid coverage for duals. This is a topic of interest for the Commissioners and an area of focus for us as staff. We have work under way on enrollment and retention in the duals demos and on care coordination.

We have also been closely monitoring federal legislation and policy changes, including things like the D-SNP permanency in the Bipartisan Budget Act passed earlier this year.

But we've also been tracking state actions. States are working to integrate care for their dually eligible populations, even as policies at the federal level are still taking shape.

The purpose of today's panel is to give you guys the opportunity to engage directly with state officials who are working on integrated care and states recognized as leaders in this field.

We have here today officials from Arizona and Virginia to speak to you guys about their experiences integrating care for their populations and then the successes and challenges that they have faced.

First, we will hear from Mr. Tom Betlach. Mr. Betlach is the director of Arizona's Health Care Cost Containment system, a role that he's been in since 2009. He reports to the governor on the program, which currently provides Medicaid coverage to 1.9 million Arizonans at an annual cost of $12 billion.

Arizona has decades of experience with managed long-term services and supports. The state did not participate in the Financial Alignment Initiative and instead aligned its existing MLTSS program with D-SNPs.

Under Mr. Betlach's leadership, Arizona now leads the nation with the highest percentage of duals aligned in the same health plan for their Medicare and Medicaid benefits, outside of demonstration authority.

Mr. Betlach is the former president of the National Association of Medicaid Directors. He serves on the board of the National Committee for Quality Assurance and is a member of CBO's panel of health advisors.

Our second panelist is Ms. Karen Kimsey. Ms. Kimsey is the chief deputy for Virginia's Department of Medical Assistance Services. She oversees the daily operations of the agency and works with the director, Dr. Jennifer Lee, to provide leadership and management to all DMAS programs, including the state's Medicaid expansion of an estimated 400,000 newly eligible adults, which will be effective on January 1.

Ms. Kimsey has over 23 years of experience at Virginia's Medicaid program, with an emphasis on

populations in need of LTSS and behavioral health services. Prior to her appointment as chief deputy, Ms. Kimsey was Virginia's deputy director of Complex Care and Services. Her responsibilities included oversight of Virginia's Financial Alignment Initiative demonstration called Commonwealth Coordinated Care, and under her leadership, the state transitioned from that regional demonstration, which ended this past year, to the current statewide MLTSS program aligned with D-SNPs called Commonwealth Coordinated Care Plus, a program that now covers approximately 210,000 individuals with complex care needs.

Ms. Kimsey also led the development of the Addiction Recovery and Treatment Services, or ARTS program, in Virginia, which was implemented in 2017 to address the opioid epidemic.

Each of our panelists will give a brief presentation, and then we'll use the majority of the time allotted for today's session for conversation between you all, the Commissioners, and the panelists.

Following the panel session and the break, we'll talk about the direction of the Commission's work on integrated care for duals.

And now I'd like to turn it over to Mr. Betlach to tell us about his experiences in Arizona.

* MR. BETLACH: Thank you, Kirstin.

Good morning, everybody. It's a pleasure to be here today to talk with you about duals and celebrate Commission Gordon's birthday. So I'm happy to be here.

Just a quick overview on Arizona. As was mentioned, we've had mandatory managed care in place for decades. The population excluded from that is the American Indian population. We are an expansion state, as was mentioned. We cover about 27 percent of the state's population. We've got 152,000 duals, and I'll talk quite a bit in my discussion around alignment. For us, alignment means that those individuals are enrolled with the same organization, both within the Medicaid managed care product and a dual special needs product. So for us, that's alignment.

And we have three different lines of business in which we've been pursuing strategies to build that alignment. So the first are individuals with developmental disabilities. We have 7,100 individuals with a 61 percent alignment, 25,000 members that are in a long-term care

program for the elderly and physically disabled, 32 percent alignment, 120,000 individuals that are not in our long-term care program, and there's a 48 percent alignment. So, overall, we're at 70,000 members aligned, about 46 percent of our duals population.

I think as we start this conversation, it's important to acknowledge the progress that's been made in this decade around dual eligible members and really the different systems that have evolved in terms of the partnership between the state and the federal government, and I would put out that there's been more progress in this decade than there was from the 1965 to 2010 period around dual eligible members.

And I'd really credit four different things in terms of that progress that's been made. The first is the federal structure that was mentioned in terms of the permanent authorization of D-SNPs, the waiver authority, and the demonstration programs that were led out of the duals office.

The second is the evolution of a delivery system at the state level, where states have gone to Medicaid managed care for long-term services and supports and really

created a platform by which you can attempt strategies around alignment and to look and identify strategies for the dual eligible population.

The third is just a willingness to partner between the federal government and state government.

And fourth, it's been really carried out by a variety of resources that are now available to support states because this is really difficult work, and we've had a lot of resources available from the duals office. We've had the National Association of Medicaid Directors heavily involved in this topic, the Center for Health Care Strategies, the Integrated Care Resource Center, so a lot of different types of support out there for states in terms of this journey.

I'm going to highlight eight different strategies, initiatives that have really helped us in Arizona in terms of our progress.

The first is the commitment from the leadership of the organization. When I came into Medicaid, the first project that I worked on coming out of the budget office was the Medicare Part D implementation, Medicare Modernization Act. I'd sit in these meetings with our

team, and I had a very difficult time understanding who would ever create a system in which we would take some of the most complex individuals and have them served by two different programs, Medicare and Medicaid, where we were then trying to figure out how to split up the benefit and transition prescription drugs over to the Medicare benefit at that point in time. And it just perplexed me and really, I think, created the will and the want to be able to do something different as it related to serving these individuals, and so we've spent the last decade-plus really working on strategies to do that.

The second strategy that we've deployed is we've had staff specifically assigned to the Medicare side of the house. So we've had resources on board that we've been willing to pay for as an organization that do things like work on MIPPA agreements, comment on the regulations that have been put forward in terms of stars and making stars recognizes the uniqueness of D-SNP programs, work with the plans, who ultimately end up employing all these individuals that we hire to take on this role, work with CMS, work with other states.

We are talking now with the State of Hawaii about

sharing this resource that we have for their efforts to educate our leadership team within the organization, and really one of the most important functions is to write our managed care contract language. So Medicaid is such a specialized unique program, and oftentimes, it's difficult for Medicaid agencies to be able to fully appreciate all the complexities of that, but to have that resource on board has been very helpful for us.

The third strategy is that we have used our regulatory position to mandate for our managed care organizations. So we require that all of our Medicaid managed care plans be dual eligible special needs plans. That's if they want to do business with us, they have to be a dual eligible special needs plan.

We require that in the Arizona marketplace, if you're going to be a dual eligible special needs plan where we will sign a MIPPA agreement, you have to have a contract with the Medicaid agency to deliver Medicaid services. So we let that be known a couple years in advance so that folks can make business decisions in terms of whether or not they wanted to bid on a Medicaid product, but we took that stance.

The third is we created a statutory structure, where if you want to create a dual eligible special needs plan in the Arizona marketplace, you don't have to go through the Department of Insurance. We're the regulator of the Medicaid plans, and you can just come to us and create that D-SNP within the State of Arizona, so that helped streamline some of that regulatory oversight for those plans.

The fourth area is we leverage our authority and our ability to mandate around trying to build alignment. So there's been a variety of different tools that have been created by the federal government to help build those alignment numbers. One was seamless enrollment, and so that was authority that existed previously. And we had all of our plans get enrolled, and seamless enrollment is for an individual who is currently served by a Medicaid plan, but becoming Medicare-eligible as a result of either aging into the program or also as a result of the two-year window around disability. They are seamlessly enrolled into that dual eligible special needs plan of their Medicaid managed care plan.

They have the ability to opt out at the front

end. They can opt out afterwards, but we've had tremendous success with this in terms of helping to build our alignment. We also worked with CMS so that as they rewrote the regulations around this, we gave them the information in terms of the importance around this for dual eligible populations and the success that we've had in terms of overall retention.

So, for example, under the old seamless conversion, over the course of a little under a year, we had 4,427 individuals enrolled, and less than 11 percent opted out. In the first three quarters of 2018, we've had 3,300 individuals enrolled and about a 92.9 percent retention rate, so very strong retention rates in terms of these types of tools to help build that alignment.

The other strategy that we've pursued is if we have in the past seen individuals enrolled on a Medicare side for a D-SNP plan but not been enrolled in the same Medicaid plan, we've then aligned on the Medicaid side with their Medicare enrollment. So we've said to those individuals, "We see that you are not aligned. We would like to align you. We are going to move you on the Medicaid side. You have the ability to stay in your

existing plan," and again, we've been very successful in terms of using that strategy.

We've leveraged this alignment then to drive more value-based purchasing. So we require our managed care organizations to have a certain percent of their spend in value-based arrangements. We used the Learning and Action Network's four different categories, and so we extended that to their Medicare D-SNP spend. And it's just a way for us to try to continue to build a value-based purchasing system through that alignment strategy.

The other strategy that we use is we enforce as a regulator. So we've had plans, for example, are able to expand on their Medicaid side, and they weren't able to bring up their D-SNP in that area in time. And so we have sanctioned that plan. We have sanctioned plans if they're not at three starts because if you're not a three-star plan on the Medicare side, then you're not able to do default enrollment, which is now the same as seamless conversion.

So it's important for that Medicaid agency to use all the levers that you can to really enforce your strategies around overall alignment.

The final area I'll mention is we leverage data

sharing. So we get information from the federal government in terms of our dual eligibles that may not be aligned. We share that back out to our Medicaid managed care organizations. We call it blind-spot data, and it's just additional information. It's not necessarily timely in terms of "I'm going to take action on that information immediately," but it helps build the overall analytics in terms of what that population or member looks like in terms of services that they're receiving outside the unaligned individuals within our organization.

So I think it's important to recognize that we do all this, despite knowing if it is done well, all of the benefits or the majority of the benefits accrue from a financial perspective to Medicare. Obviously, there's better outcomes for the individuals that are being served. We've seen that in the dual demonstration evaluations that have come out to date.

So, for example, in Minnesota that leverages that D-SNP model, similar to Arizona, they saw over a 40 percent lower use of inpatient days, 40 percent lower readmissions, higher use of home and community-based services. So I think it's important to recognize that states are heading

down this path, and they're doing it obviously with good intentions of better serving the population, but at the end of the day, Medicare is the program that really benefits from our efforts around building this type of alignment.

So just in closing, a few things I would like to touch on in terms of areas of opportunities, where you all may consider recommendations. The first is that when you look back at the demonstrations -- and we sort of evaluated the demonstrations and whether or not we wanted to do a waiver, and we just felt D-SNP, given where we were at, that we were already using D-SNPs, was the best path to go moving forward.

But one of the great things about that time was they pushed out grants to states to really evaluate what strategies they want to pursue, and when you look at the growth of managed long-term services and supports within the Medicaid space, I think there's another opportunity to reengage states because we've gone in the last decade from just a handful of states having MLTSS to today there's around 25 states.

So I think if the federal government were to contemplate some ability to provide some start-up funds --

and I'm not talking about a ton of money, but to help fund some strategy money for states, I think that that would be meaningful because, at the end of the day, the federal government is the one that's going to benefit the most in terms of really pursuing optimal strategies.

The second along those same lines is if the state is moving forward with a strategy and is successful, like I would say Arizona has been, then there should be an ability to continue to fund the infrastructure that's necessary to do that, again, not talking a lot of money, but those couple of positions that are necessary to really stay engaged as it relates to that.

The third recommendation would be to enhance programmatic FMAP for Medicaid duals for states when the states are pursuing an alignment strategy and are successful with that with higher-performing plans. So if you have plans that are doing well, you are seeing the outcomes that you desire, similar to what we did with Money Follows the Person, where there was enhanced federal participation made available to try and drive this system, I think there's a real opportunity to leverage financial alignments to help move processes along. So I would

encourage you all to think about that because, again, I think the federal government really gets the ROI on those types of investments through the savings that are generated on the Medicare side.

Last but not least, I really think there needs to be a longer-term solution in looking at recommendations around how do we make a fundamental change for the dual eligible population so that they are no longer served by these two separate systems because nobody would sit here today with 11 million of our most complex members and say, "You know what? We need to serve them out of two separate systems." We would come up with a singular approach in terms of how to best serve that population, and I really think it's time to give thought in terms of what that looks like.

I will tell you the challenges within that are if you look at a federal solution, the federal government does not have the experience with long-term services and supports and behavioral health that are critically important to this population because it's not a homogeneous population. There are all types of different subsets of the population that exists within the dual population, and

so I would encourage you all to think about that.

So, with that, I will conclude my comments and look forward to the conversation. Thank you.

* MS. KIMSEY: Okay. I think it's my turn. Good morning, everyone. It's a pleasure to be here today to talk with you about Virginia's experience with our dual eligible, our FAD, our demonstration, Commonwealth Coordinated Care, as well as our migration into our mandatory product, which was outside of the demo. So, as well, we serve 1.6 million people in the Medicaid program.

We are so excited to announce that we are going, expanding to 400,000 individuals as of January 1. We have all of our authorities in place, and we're ready to roll. Enrollment begins next week. Just had to put the plug in there for it.

[Laughter.]

MS. KIMSEY: It's just several years coming.

But we also serve about 110,000 dual eligible individuals in our program, and I have to say that on the experience related to our FAD, we are very excited to be a part of our alignment demonstration, and credit to Commissioner Bella for giving us the opportunity to do

that.

We were third out the gate. I think Ohio would argue with us on that, but we really were.

[Laughter.]

MR. BETLACH: John is not here, so it doesn't matter.

MS. KIMSEY: And so we had targeted -- and for our pilot, we targeted adults, not children. We excluded people with developmental disabilities, and we also looked at people who used a very particular program of ours, our Aged Disabled Waiver.

We also looked at our community well population, people who have had serious mental illness or maybe even addiction needs at the time, and so there are about 60,000 individuals in March of 2014 that we targeted. We had about 30,000 individuals enrolled in the program. So there's about 50 percent participation, and we were very pleased with that.

One component of it that I think was challenging for us and other states would tell you is the churn that we had related to the ability of people to pop in and out on a monthly basis, but our federal partners, I have to say,

CMS, the office was great. We did enjoy having the joint contract with CMS and with the state to combine both programs and be able to blend that rate, and the plans also talked about that, that component as well. And so as issue arose, we were working closely with them and more readily with them on how to address that.

For example, they were in the process of allowing us to lock in the Medicaid members to control the churn on the Medicaid side, and we had three health plans who were partnered with us in that particular program, but unfortunately for us, we had state legislative requirements. So we were already under our mandate that started in 2011, way before the demonstration, to migrate all populations into managed care by 2017.

So, by 2015, we were having to decide what we were going to do, and we had a great learning experience with the FAD, but we also knew that at that time, it's still a demonstration. We weren't able to expand populations to go statewide, and so that was the decision for us to migrate out of the demonstration at the end of our contract period, which was December of 2017, and move into our mandatory program that covered over 210,000

individuals, and it was all inclusive in services as well. And the demo did have certain exclusions for services which we folded all those in. For example, hospice, and also, behavioral health services were included in the demo, but we also included them on the Medicaid program side as well. So we did experience a churn but we would have had the support of CMS to lock them in if we had remained in the demo.

And also we needed to include more than dual-eligible individuals, which was another component for us. So, as I mentioned, half of the members that we serve now in the mandatory program are our duals. So we had to go statewide, cover other populations. We now include people with developmental disabilities on their acute and primary care needs. Eventually we will migrate the long-term care services.

But one of the things that we learned, and we learned this, some of the lessons. So we had, with the FADs, and I'm sure you have heard about it or will hear it with future pieces, is take your time, have plenty of time to enroll into the program, to phase in and regional processes related to that. That way it gives you the

opportunity to learn as you go, especially if you're a new state to this.

And we weren't new to managed care. We had over 20 years of experience with our pregnant women and our children and our aged, blind, disabled populations, but we were new to long-term care, and so was the long-term care system and behavioral health. And so the regional phased-in process was very helpful on that end, because we were able to make corrections as we moved.

Also, we learned this with our -- and we had a lot of support. I'll echo what Tom was saying. At the federal level we had support with CMS. We also had the Center for Health Care Strategies and other partners that helped us along the way in terms of how we moved into the system and gave us the support with our stakeholders. I cannot echo enough how much we have to be involved with our stakeholders, meeting with them regularly, ongoing, those individuals who receive the services, and their families, as well as the providers who deliver it, and our health plan partners.

So that was a very important process for us, continuous, ongoing, and it did not end as soon as the

program launched. It's constant and that's very important. And so when we actually made the decision to move to the mandatory Medicaid product, with the D-SNP combo, and we do require our six health plans that we have now, two of which were in the FAD, they have to be D-SNPs. We gave them a period of time to develop their D-SNP product and to come into compliance with that, and that was as of January of this year that they're starting off to do that.

And so we did see that important part, that even if we were leaving the demo that we still wanted that integration of care. We saw that as a critical component, and ideally would have loved to have had a continued contract with CMS on the FAD, similar to what Minnesota has, but they were so busy bringing up other states at that point. But they have committed to us that they are going to work with us to look at that, a similar type of contract related to that, and we're actually very excited about that.

I also would like to mention, for our program, on the Medicaid side in Virginia we do not have a strong penetration rate. It's about 16 percent on the managed care side for Medicaid. So we have -- you know, I would

say it's an opportunity more than a challenge for us, to actually help people to understand and see what alignment of these two programs can be for them and how it can help them in their lives and coordinating that care.

And that was another big selling point for us in managed care. You know, a lot of states go in saying "we're going to save money" and for us it was we want to better coordinate individuals' care and their experience to help them navigate at a very fragmented system between both Medicare and Medicaid. But also to bend the curve over time, to have better predictability to the costs and see where we can have those efficiencies. And we did see that and we did witness that and experience that in our demo. And so we also hope to have that happening in our program that we have now.

So we are just a year out and we look to Tom and his state and we also look to Tennessee and to Massachusetts and other states, Minnesota, that have gone before us, and now we're looking at New Jersey as well, to how we keep moving forward, because now we have the framework in place, and then how can we advance.

So right now we have the alignment for our

programs. We have 16,000 people who are aligned in the program itself, and that's commensurate to our experience right now in the Medicare scene. But we are eager to bring it up to a much higher percentage that we're witnessing in other sister states that have had more experience than we have had at this point. So we are looking to default enrollment, which we believe in, and we think will have a positive experience for the beneficiary. And they also have the choice to opt out if they wish not to stay with the enrollment. So enrolling them into the D-SNP once they become eligible for Medicare that aligns with their Medicaid managed care plan. Also, we were looking at the same process. We're going to explore that if somebody is in a D-SNP offering to align them to the managed care plan that serves them in that manner.

So those are the two avenues that we will be moving toward in the future related to that.

Another piece, too, on the learning experience, I was asked to tell you all some of the reasons why we shifted over and then also some of our experiences related to lessons learned are related to that, and how we are doing things a little differently.

In terms of the care coordination piece, we really believe in that and we've seen many wonderful experiences where individuals benefitted from that. So we believe that that happened and we have evidence that it's happened and we have it very strongly written into our contracts. And so I would agree with Tom. Your contract is really everything, in terms of the leveraging and control related to working with our partners in the health plans, but also not only in the Medicaid side but on the Medicare side with the MIPPA contracts, with the D-SNPs, leveraging that.

We have expectations around requirements in terms of the care coordination model. So we don't just say, hey, we want you to advance care coordination and then leave it up to them to figure it out. We have explicit requirements related to our expectations for care coordination. We also have ratios that we embedded in our programs. And so with the dual alignment demonstration that we had we did not have the ratios embedded in that, and so we had a varied experience with our health plan partners related to what they felt would be a proper ratio.

And so we had one experience at one point where

one plan had a 1-to-700 ratio, and we didn't agree that that was going to work. When we actually did our new procurement for the new program we set the ratios. We were very open. We worked with our stakeholders who serve those populations and represent those vulnerable populations and said "what is a reasonable ratio?" and settled on that and also with the plans, and that's embedded in our contract. We look at that annually, but that's been very successful for us.

Another thing that we did is we set up a care management unit within our agency, whose only focus is to ensure the successful implementation of care management coordination within that system. And we actually train the coordinators in the health plans and work with them every week, over 500 of them, that we communicate with twice a week. And so we continually educate and train them on the programs, the trends and analysis that we're seeing related to services, and what our beneficiary experiences are, and relate that back to the coordinators.

And so we have a very strong connection with our coordinators that way, and we wrote that into the contract that we require that participation with the plans. And the

plans are very supportive of that. At first I would think they were a little surprised to see that level of in-depth involvement, but they support it now because they see that the care coordinators are up-to-date on their information related to the program, because the churn is significant for them as well, as it is for any other program.

We also have a Medicare unit that has been created in the agency because despite our best efforts in the very beginning to say that was another program, we realized we had to learn it very well and get very used to services rendered in the Part D and the plans, and how to better work and partner with our D-SNPs and actually leverage that.

Another piece we're actually looking at, too, is maybe migrating into a FIDE SNP, into the future, that that will help as well.

So being open and transparent with our systems on both sides, I think that was very critical for us. Being very clear in expectations in our contracts. That is something we've learned about. Also with the care management side, just having explicit requirements related to that, particularly related to ratios, and we're also

very involved with our encounter data, so that is a critical, critical component. We actually built our encounter system in house and started receiving the data within the first month of the program going live, and we are also receiving the Medicare data as well, and that's another critical piece for consideration, and thank you to CMS for providing that data for us, because we have insight into the members and their experience.

As Tom echoed, we do not, in the new program that we have, realize the savings. It is Medicare that realizes the savings for our duals. And so the best thing we can do at this point, though, is we still want to enhance and coordinate that care related to that piece.

Another component, as well, for any new state starting is just the new start-up with the programs and having some grace as the program goes live in the beginning related to providers enrolling, paying claims timely. All those things are very critical components to that part, and also to the members' experience.

So that is, you know, just a, I guess, brief description of where we were and where we are at this time.

CHAIR THOMPSON: Thank you. Well, I know hands

are already going up. I know we've got a lot of folks that want to jump in. So I see Chuck, I see Darin, I see Mel, I see Kit, I see Sheldon, I see Brian, I see Toby. All right. We'll see what we have left over from that. But I get the prerogative, as the Chair, to ask a couple of questions first.

I wanted to ask you both two questions. One is both of you mentioned savings to Medicare. How mature do you think is the data around where the savings are coming from and to whom they are attributed? So if we're talking about dividing a pie, do you both feel like we really do know what that pie is?

MR. BETLACH: I would say that the best indicator of that now are the third-party evaluations that are coming back on the demos. Because they are third-party they are doing a deep dive. There's a little bit of a lag, obviously, in terms of being able to do that. But clearly in terms of what we've seen in Minnesota and Washington, and Melanie has a much better idea of where the other states are. But they're all coming back, they're showing savings, and they're showing savings, as we would all expect, to changes in utilization that largely benefits the

Medicare side, with often times some increased expenditures on the Medicaid side to achieve that -- home- and community-based services, behavioral health, and other things like that.

I mean, we'd love to see a third-party evaluation done of Arizona now after we've been at this for many years, and I don't know if your evaluation came back in or not.

MS. KIMSEY: It has not.

MR. BETLACH: Okay.

MS. KIMSEY: But we also will be evaluating our new program as well. So we have an external evaluator who will be performing that. But I echo Tom's comment looking at that.

CHAIR THOMPSON: Okay. And then just a second question, so both of you talked about what alignment is to you and where you are in terms of alignment, and the number of things that you're doing to have achieved the numbers that you're achieving now. Do you see -- what are the major ways that you're now looking at to significantly increase those numbers? You know, you continue working at the things that you've been doing and you can expect some

incremental improvement, but do you feel like there are some things that you might need additional authority for, or that you could be doing, or plan to do that would create a big jump in those alignment numbers?

MR. BETLACH: So clearly there's been conversations around the ability to passively enroll individuals beyond what the default enrollment allows for, and I think that those are conversations that should continue to happen, in terms of the ability to do that. I think that there's obviously a lot of stakeholder engagement that needs to be done around that, and oftentimes stakeholder pushback on those types of conversations.

But, you know, I think we've been -- it's been a great partnership working with the duals office in terms of getting that default enrollment for the duals population and being able to stand that up with states. But so much of this is just incremental strategies. It's hard to see something that's really a big bang strategy.

I will tell you one of the challenges that we're still wrestling with is. Oftentimes in the Medicaid space we have competitive procurements and, you know, sometimes

that's statutory and I'm a believer in competition, but at the same point in time it sometimes results in undoing the work that you've achieved, in terms of alignment.

And so there is some authority that exists at the federal level to help try and mitigate the impact of that. We tried to leverage it this last time around. I think we didn't do enough front-end planning to make sure all the plans had their Medicare network in place when CMS had to do the evaluation. So the next time we go through this we're going to have to back up our timeline to recognize that.

And so I think one of the major challenges states face is you can spend all this time, you can get up in terms of having high alignment and the next thing you know the plans that had built that alignment are no longer serving that region. So that's a major challenge in terms of that.

MS. KIMSEY: And we would echo that as well, with the passive enrollment. I think that is going to be a critical component. And also just an educational piece. I think I touched on that. And I would agree it's incremental. But we have moved so much faster over the

last several years than we ever saw any movement, for many years prior to that. And that also speaks to the support at the federal level as well states engaging.

And so helping to continue to educate, provide support to states to continue to migrate this way related to that, in terms of -- and increasing the population, and for us it's a matter of getting out and educating our members, as well, and families and other key stakeholders, to making sure that they see the benefit to the alignment.

MR. BETLACH: The blueprint is there. The authority is there. I think, to a large extent, what is a limiter is the ability of states to have resources to take this on.

CHAIR THOMPSON: All right. So just a reminder, we have Chuck, Darin, Melanie, Kit, Sheldon, Brian, Toby. All right, so Chuck.

COMMISSIONER MILLIGAN: Feels like an auction.

[Laughter.]

COMMISSIONER MILLIGAN: I have two questions, the first one for Tom and the second one for both of you. And picking up on where Penny started, have you attempted, in Arizona, to quantify the Medicare-related savings? Because

when you, in your recommendations to us, talked about enhanced FMAP for states that do a dual alignment kind of model, it's a more kind of -- seems to me more politically feasible path than sort of taking on the Medicare trust fund as a version of shared savings. But it would be helpful to have a sense of what that enhanced FMAP would be that would still produce savings for the federal government and incent states.

So I'm curious if you've tried to quantify the Medicare-related savings your program has produced.

MR. BETLACH: No, we haven't been able to. Would love to. Came up with the recommendations on the airplane on the way here last night, and they seemed like they were plausible to me. But, you know, we'd love to do the third-party evaluation. I think, to a large extent, I'm basing that on what's transpired in terms of those evaluations that have been done through the demo side of it, because, again, those have the most rigor to them and I would hold up. There's been some analysis done but it's been plan sponsored and so you get a -- I think you need that third-party evaluation.

COMMISSIONER MILLIGAN: Thank you. The second

question for both of you, in an early kind of dual-eligible related panel several months back one of the issues on the D-SNP side is that how CMS measures geo access in terms of service area is very different than how Medicaid tends to think of geo access. And I'll just give you the example in New Mexico, where I work. We wanted to get our D-SNP into many counties where we've just failed to meet the CMS test because there just aren't providers. And CMS has not been open on the Medicare side to aspects of non-emergency medical transportation, getting people into more urban service areas. They've not been very open to telehealth as a workaround for geo access.

So I'm curious to the extent that you require alignment with the D-SNP and to the extent that it's hard sometimes on the Medicare side to go into some of those rural and frontier counties, if you have any insight or suggestions for us in terms of the federal advocacy piece of that, or just insight in general, how you've tried to address that within your markets around just your desire to align into certain counties where meeting that federal geo access standard is difficult.

MS. KIMSEY: Actually, I would like to speak to

our experience with the FAD. Our alignment demonstration actually gave us that flexibility. So when we brought up the issue with the geomapping, how it's different for the populations in terms of the subspecialty providers, that's where we were encountering problems, even related to the FAD. And after we worked with our CMS partners they actually opened that up and allowed it to be for the total unique population that we were serving versus the total Medicare population for the state.

And so I would invite that there be some consideration for that to be on D-SNPs that are not in the FADs. That could be of great benefit to other states. Since they did open it up for that and the experience has been positive, perhaps that would be an open avenue for consideration.

We have not had that experience so far with our D-SNPs but perhaps because we had such a small population at this point. And so that has not been our experience, but in the past they have given that, and so I would encourage the Commission to talk with them and explore with them is that an option.

MR. BETLACH: Arizona has many of the same

challenges New Mexico does. We have the advantage of having only 15 counties from the purposes of evaluating. We've tried to keep our regions large. It's one of those areas where having that staff person has come in helpful because they've worked hand in hand with the plans and gone to Medicare around the exception process and talked about exactly what you mentioned. NEMT is available for this population and other things like that. There is that exemption process that exists. It's sort of a black box, not a lot of transparency around what that looks like. I think we'd prefer to have a little bit more insight into, you know, what that looks like. But, again, our staff expertise to be able to help support the plans through that process I think has come in handy on multiple occasions.

CHAIR THOMPSON: Great. Darin.

COMMISSIONER GORDON: Karen and Tom, thank you both. I really appreciate your testimony.

You both touched on the staffing resources and expertise that's needed, and while you guys have invested into it, we've invested in it when I was in Tennessee. My sense is that a lot of states are lacking some Medicare expertise, and not even just the purest Medicare expert,

but also understanding all these different models and approaches and paths they could potentially go down and the lift of each one. Is that fair from your interactions with your peers that that's --

MR. BETLACH: I agree with that completely. I mean, we had a breakout session on this at our last National Association of Medicaid Directors meeting. It was very well attended, but you had the full continuum, and you had a lot of folks down here. They had stood up managed long-term services and supports on their Medicaid side. They were trying to figure out a strategy for Medicare, but they were just -- they didn't even know necessarily where to start in terms of understanding D-SNP authority and they had heard CMS might be taking on new demonstrations of states that were interested or even the flexibility that the administrators talked about. So that's why I mentioned really as my first recommendation plow a little bit more money back into this just to see if you can get states willing to try and build some models that really leverage the infrastructure that now exists that didn't exist a decade ago.

COMMISSIONER GORDON: This question is for you,

Tom. I think, Karen, maybe it depends how long you've been in the alignment side for whether or not this would be appropriate, but if so, please weigh in as well. Have you done anything on the rate development side in those situations where you do have the alignment, you're recognizing that there is the strength on the D-SNP side and what's happening, that at least -- you know, I know you're sitting more on the Medicaid side, too, but conceptually it is functioning as a singular product, albeit an imperfect one.

MR. BETLACH: Yeah, the actuaries, what they've done is they've built separate rate cells for dual-eligible individuals, and they're tracking that and looking at the utilization. What they haven't done necessarily is then build the Medicare data back on top of that. Typically actuaries like to have three years' worth of information, and we've only got about two now in terms of that requirement where the plans have to submit the encounter data so that it actually rests within our system.

So that's clearly something we can look to do in the future, but -- I don't remember how long you all have been capturing that data, but for us it's only been a

couple years, so we actually have enough experience now where we can start doing that. But we have created the separate rate cell, recognizing this is sort of a distinct population.

MS. KIMSEY: We've done the same thing with the rate cell, but we have not started to factor in the Medicare expenses at that point.

I also just want to touch upon the -- having been the state that started on a shoestring budget, we did not receive additional grant support or funding related to how we started. We just started it out of sheer will to move into the MLTSS environment, and we just committed within our agency it was a priority, and we literally shifted positions into different components and just made it happen.

And so as for our Medicare unit, when somebody left in another area, we just took the position and flipped it into something else because we defined it as a priority for our agency. And so I would, you know, echo the need, if there are additional funds available for states to move that way, but it was for us a priority because it was a priority for our administration and for our legislature,

but not every state has that type of support. And so in order to get started, they will need those resources.

COMMISSIONER GORDON: I think only you, Karen, had mentioned that you're contemplating the FIDE SNP.

MS. KIMSEY: Yes.

COMMISSIONER GORDON: And in our state, we had one that was FIDE SNP; the other two were D-SNP, but in other words moving to FIDE SNP. But I'm just curious, what's your thought process there?

MS. KIMSEY: Well, we understand that it also helps for better alignment related to the members and also risk-adjusting to their actual cost needs.

COMMISSIONER GORDON: To the benefit of the plan.

MS. KIMSEY: Yes -- well, it's the benefit of the plan, but as the plan benefits from that, we'll tie into the contract for our requirements and expectations.

COMMISSIONER GORDON: Exactly. And that's, again, the prior comment, which is, yes, they're two different products, but you have forced a linkage there, and so you have to think about them singularly.

MS. KIMSEY: You're right.

COMMISSIONER GORDON: But the benefit being that

that does then also, when you're looking back at rates, that's another component that gets factored into that overall map.

MS. KIMSEY: Right.

COMMISSIONER GORDON: Helpful. Thank you.

CHAIR THOMPSON: Melanie.

COMMISSIONER BELLA: Thank you both. You're amazing. The work is amazing. A huge plug, by the way, for building state capacity. I think the grants of financial alignment states got were a million dollars. A million dollars on a $350 billion annual program is nothing, and it did make a difference. So I have two questions.

One, you guys are leading, Arizona, you and Tennessee especially were leading the requirements for your managed care plans to be D-SNPs

MR. BETLACH: Mm-hmm.

COMMISSIONER BELLA: And, you know, you guys are doing the same, but the dual-eligible program is like a constant game of whack-a-mole, right? So there are now a lot of tools that states are using with their MIPPA agreements to align that, but you see this emergence of

what everybody is calling look-alike plans. So these are Medicare Advantage plans that are coming in, targeting only duals that are not coming in as a D-SNP because they don't want to have to get state or can't get state MIPPA contracts or they don't want to do the model care requirements. And I think rumor has it in 2019 36 states will have these look-alikes.

So I'm curious of your thoughts about how should the -- is there anything you want to say to the Commission about how you're going to think about dealing with that? Because it could significantly undermine alignment in states. So that's one question.

The second question is just as you think about being able to recognize, share the savings between both payers, I don't think there's anything prohibiting you from actually having some sort of shared savings agreement with your plan, or that's a side agreement on the Medicare side. And I'm curious if you're thinking about doing that and if there's anything that you feel is a barrier to your ability to do that that the Commission could contemplate.

MR. BETLACH: I'll take on the second question first. I don't know that there's a barrier at the federal

level. I think there's probably a barrier for us at the state level, and we would need state statutory authority to do that. So I don't think that's necessarily a concern within the Commission. I think it's something that we as the Medicaid agency would have to go to the legislature.

On the first issue, you know, this is a new concern for states. There's ever a continually evolving marketplace as it relates to different models that are out there, and so I think what we're going to do is evaluate to see what happens within the Arizona marketplace, and if necessary, ultimately try and identify if there's plans out there that are targeting just our dual population, try to create some parameters and limits around that. But we're going to have to wait and see how that evolves. So we're interested to see what comes online in 2019 and what type of impact it has, and our strategy will have to be somewhat reactive to what's in the marketplace, not proactive, unfortunately. But it's a state-level issue as it relates to the Commission. I mean, I think you're a more knowledgeable person on this than I am in terms of what a potential statutory structure may look like or even something that CMS can do as it relates to trying to really

get back to the true purpose of what the D-SNPs are doing in terms of really being able to build alignment and not just sort of cherry-pick at that point in time.

MS. KIMSEY: I would echo that also. We're seeing increased growth in I-SNPs as well, not just the MA plans. So the I-SNPs are going in, and they're picking the individuals off of the benefits, our programs for that, and the state has no influence or control over those contracts either, similar to MA. And so we've begun a national conversation, alerting other states, hey are you seeing this, not just for the MA but for the I-SNP growth. And people are starting to pay attention to it as well, but some of it also comes to the marketing strategies as we have no control over or little control over. We can work with our D-SNPs and control their marketing strategies, but not the others. And so that I think would be an interesting area to also target.

MR. BETLACH: Well, and I think there's clearly an opportunity there for the federal government to address that.

MS. KIMSEY: Absolutely.

MR. BETLACH: I think when we look at who's in an

institution, we know that two-thirds of the time Medicaid's the payer involved there. And so if you have an I-SNP, it seems to me there should be some state role in that knowing that Medicaid's going to be part of the population being served.

MS. KIMSEY: I agree. I think that an I-SNP coming in should have an agreement with the state in order to operate.

CHAIR THOMPSON: Okay. Kit.

COMMISSIONER GORTON: Good morning. Thanks for coming. So you all have talked a lot about key success factors in your programs, and that's very helpful. But this time of year, we're all reminded that nobody bats a thousand, and I sort of wonder whether you have observations about decisions that you might have made differently. You have the opportunity. You are leading states. People are paying attention to you. I just want to give you the opportunity to say to the Commission and to the broader audience, are there things that you would recommend people not do, again, mistakes that you made, things that you learned from, things that didn't play out the way that you intended them to?

MR. BETLACH: You want to go first?

MS. KIMSEY: I'll start.

MR. BETLACH: You have recent experience moving back and forth.

MS. KIMSEY: That's right, and so I think the one I would touch on first and foremost is the care coordination, care management, and that we didn't start with ratios, and stronger expectations for our requirements related to what that looks like. And so there was a lot of confusion when we first started, and I'll give an example like with the nursing home industry. They just said, hey, we were already paid to take total care of this person, what good is the plan going to do other than just another layer on top of us?

And so we had to spend quite a bit of time with them to outline what that role actually looked like and how the benefit would be realized for them and for the member. So we always start with the member, and then we work around with the other systems. And so for us, that was a significant learning curve, and to the point where that's why we have strong ratios in place, and I would offer that as one of the biggest ones that we had.

MR. BETLACH: The redo we want is clearly around the competitive Medicaid bid side and the fact that we now have new plans in certain regions and that those individuals that are being served are now unaligned. And so that member then has to figure out, again, am I going back to Medicare fee-for-service? Am I going to do another MA plan? Who is this new plan that's serving me? And so, you know, I just think it's an unfortunate reality that I thought we had a tool for and we needed to do a better job as an organization recognizing the front-end planning, and even though we spent two years leading up to this procurement, that is clearly one of the areas that I would like a redo, and I think it's something state Medicaid agencies need to be cognizant of in this journey. As you go through those competitive Medicaid procurements, what is it doing to your alignment? And what are the strategies in terms of really using the authority that now exists to try and make that less impactful on the member?

MS. KIMSEY: I have one more tiny one. So what defines a clean claim? And that's been a very interesting concept. We said clean claims within periods of time -- because, believe it or not, even though the federal

standard is 30 days, we paid within 14 under the fee-for-service model. And also the Medicare side, they're fairly used to a regular process. And so we had providers come and complain to us plans weren't paying timely, plans were saying they were, so clean claim has to mean a complete full payment claim, not partial or incomplete payment. And so we had to define that, but we found ourselves being repeatedly pulled into the Medicare side as well to ensure those claims were paid timely for them, even though we weren't involved, you know, don't oversee that program, we helped with those claims resolutions problems. So that was an unexpected twist for us, and we've straightened that out in our contract language.

CHAIR THOMPSON: Great. Tom, Karen, we're almost at time, but we can run late if you can so that we --

MR. BETLACH: I can.

MS. KIMSEY: I have a --

MR. BETLACH: A meeting with the governor, right?

MS. KIMSEY: In a few hours.

CHAIR THOMPSON: All right. We won't --

MS. KIMSEY: But I can give a few more, a couple more.

CHAIR THOMPSON: Okay -- impose too much on you, but I'd like to get the Commissioners, all who want to ask questions, to have their chance at you.

MS. KIMSEY: Sure.

CHAIR THOMPSON: Sheldon.

COMMISSIONER RETCHIN: Well, thanks to you both for being here, and I have a long association with Karen back at DMAS, so a special shout-out, and really a shout-out to Melanie for now -- I think she's been a terrific addition to the Commission, and this is such an important area, so I'm really delighted we're spending more time on it.

I have, I guess, a question, back to both of you, but maybe as much Tom as well as Karen, and I'll extend the metaphor that I'm looking at opt-out rates and some of the issues that are related to that. And in that case, I'm reminded that actually batting .300 gets you in the Hall of Fame. These opt-out rates have been pretty high in some areas of the country and then not others, and I'm interested in whether -- it doesn't really seem to -- they don't really seem to follow the Medicare Advantage penetration rates. Maybe there's some association. But

I'm intrigued, first of all, why. I never could figure out why MA has had such a difficult time in Virginia and have low penetration rates and whether, Karen, you have found that that had some issue to do with the opt-out rates and some of the alignment initiative; and then, Tom, how you were able to speculate on the 11 percent opt-out rates in Arizona.

MS. KIMSEY: I did want to shout out to Commissioner Retchin because it was his plan that took the leap with us under the FAD.

COMMISSIONER RETCHIN: Lost 21 million.

[Laughter.]

MS. KIMSEY: And we're so grateful.

COMMISSIONER GORDON: You invested. You invested 41 million.

MS. KIMSEY: But, you know, if you'll recall, we have a pretty rural area out in southwest Virginia, and managed care is considered a dirty phrase. And so people tend to feel comfortable with the Medicare environment under fee-for-service and would say, "I'm just going to stay there, thank you," and would not even engage it. So that's one of the -- that's why I was talking about an

educational process that we need to do out there to help people better understand, and a lot of people don't even understand they're in managed care Medicaid. They think they're with Premier or they're with Anthem. They don't even understand what that is. So for us, it's an educational component. And, also, on the FAD side, it absolutely had to do with providers, hospital systems, physician groups, and long-term care providers in particular, saying if you participate in this, you have to find somewhere else to go, and people would become very distressed, and our federal partners actually had to reach out and send a letter saying, "You can't batch disenroll people. That goes against your licensing requirements, and you'll be tagged on that."

Related to that, we had a huge struggle with that. It had not to do with people choosing to leave, more than the influence of the providers serving them influencing them to leave.

MR. BETLACH: Well, as a Milwaukee Brewer fan, I'm a little distressed by all the baseball metaphors, but I'll move on beyond that and get into the conversation in terms of this, and I'm sure Commissioner Douglas has

thoughts on the disenrollment experiences as well given California.

But, you know, I think it's all so much dependent upon the local environment. MA has a very strong penetration rate in the state of Arizona. We've had Medicaid managed care for three-plus decades, very well accepted as the delivery system in our state. In terms of the 90-percent-plus retention on the default enrollment, I mean, those individuals already have experience with that plan on the Medicaid side, and so they know who Mercy Care Plan is, they know who United Health Plan is. And so I think so much of that helps in terms of achieving a success rate like that, and I know our numbers are also very reflective of what's going on in Tennessee where they have a 90-plus-percent retention rate through that process. And, again, I think it's reflective of the relationship they have built with that organization.

And so, you know, I knew that we were having tremendous success on D-SNP alignment when we sat down with our nursing facility partners who, again, you know, they have worked a long time with managed care in the state of Arizona, but they came to us and they said, you know, we

need rate increases because we're seeing a lot fewer hospitalizations for our individuals that are in nursing facilities because of the work being done by your managed care organizations, to which what does that say about the incentives that have been created by the federal government where you need nursing facilities that have to have people to go into an inpatient setting so they're viable? I mean, how perverse is that in terms of really creating a structure?

And so I think so much of what plays out on these different types of enrollment mechanisms are really dependent upon sort of the local culture that's in place.

CHAIR THOMPSON: Brian.

COMMISSIONER BURWELL: I'd like to echo thank you both for coming. Particularly nice to see Karen, one of my best former colleagues I've ever worked with. And, Karen, I will give you the first question. I applaud your focus on care coordinators, care management. I think it's an extremely important part of integration. The person who's actually in the home knows the member the best, and a highly trained, highly motivated care coordinator I think is key to the success of these kinds of models.

I'm interested in how you tried to integrate that across both your D-SNPs and your MLTSS plans. I heard many stories of people having two different care coordinators and getting confused who pays for these people. Are your Medicaid plans picking up the entire cost of this? Are your D-SNPs picking up some of the cost? How are you managing this?

MS. KIMSEY: We have the same care coordination requirements, aside from the ratios, embedded in our MIPPA contract as well, as with our Medicaid contract. So we aligned them for that purpose. But as for the cost for the care coordinators, I mean, we have commitments and work with our plan partners that an individual will have the same care coordinator, not two different ones, for their Medicare and Medicaid benefits if they're aligned. And so that's the optimal piece that we shoot for.

As for the payment for it, I mean, at this point we are absorbing the cost -- that's how I understand it -- on our admin loads related to their costs. So I'm not sure. We haven't worked to -- just because it's just within our second year working with the MIPPA contracts to this level, started to look at maybe shared costs related

to that on the care coordinator side, for the admin costs at least.

COMMISSIONER BURWELL: I guess we each get two questions. So my second question is to Tom. At the end of your presentation, you talked about the longer-term solution and having one program for duals and then commenting that it's probably not a good idea to give the driver of the bus to the federal government given their lack of expertise around MLTSS or LTSS, which I agree with. But you didn't say about the other -- you know, the -- what you didn't say was then, well, what are the barriers to giving it to the states?

MR. BETLACH: I think some of the barriers just exist within the concerns around states and how they manage. I think what you're hearing from are a couple of states that are very mature. There are other states around the table -- and Melanie obviously, through her efforts at the federal level -- that have spent a lot of time on this. But we've also talked about those states that have not had the bandwidth to be able to really spend a lot of time on dual-eligible members. So I would think that some of the concerns around any type of that strategy would be what do

you do with those states that historically have not pursued a lot of different strategies in terms of creating alignment and pursuing other things like that.

COMMISSIONER BURWELL: Do you also see a potential collaborative solution? Because this seems to be the big --

MR. BETLACH: Right. I mean, at the end of the day there has to be collaboration, just as there is on the Medicaid side, right? States don't stand alone on Medicaid. It's a collaborative effort. I'm just saying that at the end -- when you look at the structure, we would never create a system like that now. So why should that be the reason that we continue it on in perpetuity.

MS. KIMSEY: Absolutely.

COMMISSIONER BURWELL: Thank you.

CHAIR THOMPSON: Okay. Toby, you get to take us out.

COMMISSIONER DOUGLAS: So there's one I was going to ask on the provider side, but I'll leave that alone. Thank you both for coming. The final one will be around behavioral health. We haven't really talked much --

MR. BETLACH: Right.

COMMISSIONER DOUGLAS: -- about behavioral, and many states there's carveout or separate systems, and yet a huge part of integration. So if you could talk about what you've been doing in that area.

MS. KIMSEY: Well, I'm excited about that one because I've been living and breathing that very heavily for the last eight years. And so we've fully integrated that as of January of this year into our managed care systems, and so we firmly believed we saw a huge disconnect with carving it out, that people would receive services and supports, and even though we reported it into the plans, it would come later. They wouldn't know necessarily. There was a lack of connection with our primaries in terms of the care that they were receiving. And we actually did a study with Colorado, the Farley Center, that looked at touch points. Where do people actually receive behavioral health services? And the reality is that 42 percent of all of our members received it through their primaries. It's not necessarily through -- their primary care physicians, not through the behavioral health systems. And for children it's in schools.

And so we actually are moving and working in

tandem with our health plan partners because we have a very robust mental health system. We spend almost $1 billion a year on behavioral health. But it's primarily crisis-driven. It's not trauma-informed, preventive-focused, and so our evidence-based -- like our ARTS program is, our addiction and treatment. And we are working over the next year to create that north star with our health plan partners and our systems in place to design that continuum of care to better reflect members' needs and where they are and meet them where they are. And that will include integrated behavioral health and primary care platforms as well under value-based payment strategies.

So we're really excited about that, and -- because at one point we were trying to make fixes here and there, and it was like playing whack-a-mole. You were so right. I use that all the time. And any time we'd make a fix here, it would balloon out somewhere else, and it wasn't always for the positive benefit of a member or even the most efficient for high quality or efficient costs to the Commonwealth. And so that's where we're heading. We're very excited to have our plan partners --

COMMISSIONER DOUGLAS: [inaudible] contracts,

too?

MS. KIMSEY: Yes. Yes, we will be.

MR. BETLACH: So that's a very important question, and we could spend a whole other presentation --

MS. KIMSEY: Yes.

MR. BETLACH: -- talking about integration and integration efforts particularly in Arizona. So this has been a multi-year journey for us. We have been focused on actually three layers of integration. The first is the policy where we used to have a separate state agency that was involved in behavioral health services. We merged that into our organization, and so I'm a Medicaid director that has control of all the block grants. So all the substance use disorder funding now flows through us, flows through the managed care organizations. Along with that came resources for housing for individuals with serious mental illness. So the Medicaid agency in the state of Arizona is now the third largest housing authority in the state of Arizona. We have employment support resources. And so we have all this expertise now that sits within a singular organization, really focuses on the contract and the policies around supporting integration and the delivery

system.

At the payer level, we've braided all the funding streams, so the plans are responsible for the full array of services, so we know with individuals with serious mental illness, 40 percent of that population are dual-eligible members. So we have products in Arizona who focus on individuals with serious mental illness, a full array of services, including over 5,000 individuals that we're housing with state-only dollars. With that population, we're building housing support, employment support services around those individuals. We have a third-party evaluation that's coming out on that model. It's not out public yet, but some of the results are great. So COPD, asthma admissions, gone from 130 per 1,000 down to about 95 per 1,000, as just an example of some of the outcomes associated with that.

So behavioral health is critical. It's one of those important services that exists within the Medicaid that's not robust in Medicare, and when you look at the impact on some specific services like peer support services and other things like that that Medicaid's able to bring to the table, incredibly important. And so we've integrated

at the policy level. We've aligned all the funding streams at the payer level in order to support providers to be more integrated in terms of serving our population, so that it's not up to the member to have to navigate all these different systems of care, but the system is there to serve the member.

CHAIR THOMPSON: Great. Tom, when that third-party evaluation is publicly available, I hope you'll shoot a copy over to us --

MR. BETLACH: We will, yes.

CHAIR THOMPSON: -- so we can be sure to take a close look at that. That's very interesting.

All right. We've taken beyond what we allotted for your time, but that's no surprise. This is a common theme when we get some state officials in here talking about their experiences. And you two are among the leaders around this subject, and we really appreciate your coming here to share your insights and your expertise. You've given us a lot to talk about, and I'm sure we'll continue to rely on you for additional thoughts as we go along our process. So thank you very much.

MR. BETLACH: Thank you for having us.

MS. KIMSEY: Thank you.

[Applause.]

CHAIR THOMPSON: So we will take a break and be back at 10:30, and then we will pick up a Commissioner conversation to follow up on what we just heard.

* [Recess.]

FURTHER DISCUSSION: STATE EXPERIENCES INTEGRATING CARE FOR DUALLY ELIGIBLE BENEFICIARIES

CHAIR THOMPSON: Okay. Welcome back, everyone.

We'll pick up, then, with this subject in a Commissioner conversation.

First of all, again, what a rich and informative conversation we just had, and I think it really builds well on some of the initial discussions that we had in our September meeting, hitting some of the same things, but I think giving us a deeper understanding about some of them and then identifying potentially some new issues for us to think about.

So, Kirstin and Kristal, we talked about -- can you just remind us so that Commissioners can have in their minds when the last time we did a chapter on duals was, so that we can think about what the shape perhaps of some

upcoming chapter next year might look like?

* MS. BLOM: Sure. So Kristal and I were just doing a little research actually because the last time we did a chapter was before both of us were working here.

[Laughter.]

MS. BLOM: But it was in March 2013, and it was titled "Roles of Medicare and Medicaid for a Diverse Dually Eligible Population." It talked about the different roles that the two programs play. It looked at like spending between the two programs, things like that.

Since then, obviously we do have other publications. We have the data book, which we do every year. We have issue briefs on the duals demos.

Oh, also, in Kristal's MLTSS chapter in June of this past year, there was a section on integrated care because we thought that you guys would be interested in moving forward on that. So that's where we are.

EXECUTIVE DIRECTOR SCHWARTZ: Also, I believe it was in 2015, we did a whole series of empirical work and then had a policy discussion around Medicaid payment for Medicare cost sharing. It started off "What is the effect of Medicaid payment policies on access?" and it sort of

broadened out from there as well. We have done a few things as a Commission since 2013.

CHAIR THOMPSON: All right. I'll start off the conversation by suggesting maybe a path.

It seems like we have enough data and state experience to draw upon to try to develop something around supports and activities states need to engage in, in order to promote alignment. In that context, there could be identification of these strategies that have made some states successful, things that they've learned as a result of implementing those, ways in which we could contemplate changes to federal authority or the need for additional resources.

As always, in this arena, we sometimes confront this question about whether we would be making recommendations about Medicare policy, which is outside of our brief, but I think there are some places where we are going to rub up against that a little bit. And we'll have to navigate that, but some of the issues around the look-alikes and other things that affect the market in which the state is operating when they're trying to achieve a set of objectives and then maybe there's some competitive force at

play that present challenges and so forth.

But it seems like that could potentially be a rubric around a number of these issues that we've talked about in terms of, for example, what do we know about savings? What do we think about the attribution of those savings? What kinds of things can the federal government do to be and continue to be a good partner to the states in helping promote some of this? Are there some other Medicaid-specific policies at the federal level that are barriers or impediments or helps where we need to be focused?

Yes, Darin.

COMMISSIONER GORDON: I like what you're suggesting around addressing some of those potential barriers or those new kinds of created entities or approaches that are starting to undermine where there's been some progress and shining a light on that. I don't think there is any reason why you wouldn't require like a MIPPA agreement for I-SNPs or in dealing with these -- what did you call them? -- the look-alikes and trying to address those as well.

To the extent that you're basically a D-SNP and

you don't have a MIPPA agreement and you're not exchanging information with the Medicaid agency, you're not looking at their expectations on coordinating with the other part of that equation, then it really begs the question of how you could be a D-SNP In that scenario.

Granted, I think Melanie has made the observation that, in some cases, they're doing that because they're not being allowed. They're not getting a MIPPA agreement, so that's something that's being navigated.

But I do think pointing to those new kind of creations as being a hindrance to a particular alignment pathway, it's worth saying something about.

CHAIR THOMPSON: Bill.

COMMISSIONER SCANLON: I guess there's an area where I think we're not ready to learn enough in the short term, but it was mentioned the federal government has very limited experience with LTSS, and the states have a whole lot more.

But when you look at it -- and I'm extrapolating from the dollars -- there's incredible variation in that experience, and I feel like that we need to know what that variation means for beneficiaries.

LTSS to me has always been this problematic area of what exactly is the role of formal support and then particularly what is the role of subsidies of formal support. Knowing that, I think it's critical to moving forward in terms of justifying the investments or expansions of the investments, and we haven't done a good job forever, I guess is kind of the way I'd put it. I think we really need to understand what is the impact for individuals and their caregivers from different levels of services and different levels of investments. That to me is as important or more important than any kind of savings that come from different arrangements.

CHAIR THOMPSON: So reactions to that or comments on other --

COMMISSIONER GORDON: I have a question. Are you saying on the LTSS side in trying to understand -- I was trying to see if that was more like a sub-point to kind of the dual alignment, or are you saying that the issues around what is going on in LTSS is paramount, coming to the conclusion that alignment is good? I'm not following you.

COMMISSIONER SCANLON: Well, I mean, it's partly an issue of taking advantage of the opportunity of

alignment presents, and if we're going to be studying sort of what is happening as the result of alignment in terms of the services that are being provided to these individuals -- this is a question we should have been asking sort of even when we were paying fee-for-service, which we didn't, but now as we are moving forward and we want to make a greater commitment to an aligned approach and we talk about evaluation is essential, I'm saying that I think we need to put on the table that a part of that evaluation needs to be what are the consequences in terms of the differences in service delivery on the LTSS side.

And then that will translate to when you're engaged in a contract, engaged in contracting, what are the standards you put into a contract for performance. I think we have to have that eventually.

CHAIR THOMPSON: Melanie.

COMMISSIONER BELLA: I'm not sure I 100 percent understand exactly.

I would say that for the financial alignment evaluations, they all have prescriptive requirements around care models for LTSS and care plans and this and that, and RTI is evaluating each of those pieces. I don't know if

that's the evaluation you're talking about or if you're saying -- I mean, there is an evaluation to be done about the correlation between a state's LTSS program and Medicare post-acute spending, for example. Hilltop did this years ago to show the relationship between a well-funded, a well-resourced Medicaid system, and what that does for people and sort of the totality of the cost. And I think those are important relationships to understand.

So I'm not 100 percent. I'd just mention the evaluations, and they're slow, and they're -- no offense to any of the academicians -- academic. And so the states have been making changes, so they may or may not tell us what we want.

But the point I wanted to make is there's a tremendous amount we could do to help states, but there are also a lot of organizations out there, like the integrated care resource centers, CHCS, and others. I mean, they're responsible for putting together like these technical assistance tools on how to do a MIPPA contract and how to think about this. I feel like there's an untapped area for people that are sort of flagging regulatory or statutory misalignments in the Medicaid and Medicare program that are

impeding alignment. That as we're getting more experience in alignment, these become bigger issues than they were in the beginning.

So I would kind of throw a vote in for focusing on those things that are getting in the way because they weren't the same things that were getting in the way five years ago. There's new things getting in the way.

So while I'd love to see us build an amazing Medicare team in every state, I don't think that's as relevant for us as it is to continue flagging these things. And then it does require, though, that these are things where we're going to bump right up into Medicare, so understanding how we can continue to work closely with MedPAC.

CHAIR THOMPSON: In the context of my suggesting something like here are the enablers and here are the barriers, you're more interested in the barriers because you feel like there's more attention being paid to --

COMMISSIONER BELLA: I mean, I think if it's like -- so enablers are like default enrollment and cross-walking and this and that. There's a bunch of people telling states how to do that. There's not as many people

saying, "We still have an issue because Medicare regulation doesn't allow this," and for a state to align, this happens, or "Medicare regulation trumps." So there's still --

CHAIR THOMPSON: Yeah.

COMMISSIONER BELLA: There's still an area of work to be done there.

Yeah, there's a ton of work to tell the states on enablers. I'm just suggesting some other folks might already be doing that.

CHAIR THOMPSON: Yeah. Sure.

COMMISSIONER BELLA: But I'm not sure that they're doing the other piece.

CHAIR THOMPSON: Right, right. Okay.

Chuck. And Alan wants to get in, Brian wanted to get in. Others right now? Okay.

COMMISSIONER MILLIGAN: I do think it would be helpful.

I was talking to Tom after we broke for a second. I haven't read the CHCS materials on MIPPA, and I guess there's sort of a compendium or a side-by-side comparison.

I think learning a little bit more about best

practices in MIPPA would help us, especially around the look-alike issue, kind of what are the factors by which we would determine that the states advancing good policy around D-SNP in a way that might inform us around any federal commission kind of recommendation around look-alikes if we want to weigh in on this.

I do think having a little bit more kind of insight into the spectrum, and to me, part of it is -- and we heard some of this from the panel -- what are the must-haves in a MIPPA agreement for it to really work? Care coordination is a piece. Encounter data is a piece. Some of that, I think we need to start thinking about what does alignment look like in terms of kind of the minimal viable product, if you will, piece of it.

But I want to talk about an enabler that we haven't really touched on yet, which is the enhanced benefits in a D-SNP. I'll sort of talk about United, but we're, by no means, unique. This isn't a sales thing because we're not unique in terms of how this is done.

But in our D-SNP, we offer dental benefits, including twice-a-year cleanings and dentures and things. We offer eye exams and eyeglasses. We offer over-the-

counter medications. We offer meals after somebody is discharged from a hospital for a period of time so they can have stable food. There's expansions now into more social determinants of health that are part of D-SNP. We offer transportation, a whole other kind of array, the 24/7 nurse line. We offer a personal emergency response system, like "I have fallen. I can't get up" stuff.

So I think part to me -- and the reason I'm getting into that is, What determines the opt-out? And some of what mitigates opt-out is people getting benefits inside the D-SNP that they are not going to get in original Medicare, and so there's the member side of it, which creates stickiness. There's a provider side, which creates stickiness too, around quality bonuses for Stars and HEDIS.

To me, one of the things that I would like to learn more about in terms of just the difference between 16 percent aligned in one place and 48 percent aligned in another place is what are the factors that influence that.

I don't think it can just simply be explained by provider resistance to managed care. I think there are other elements of that, that enable alignment, enable stickiness with a managed Medicare program, and to what

extent -- when I get into, kind of go into that whole list of enhanced benefits and so on, to what extent is a state influencing in the MIPPA process what they want their D-SNPs to offer that can help to take pressure off of states about dental benefits or vision benefits or HCBS benefits for people who don't necessarily qualify for Medicaid LTSS.

The other one, while I'm kind of on a roll about this, the state fiscal impact for D-SNP -- and, again, we're by no means unique, but we buy down the state co-insurance and deductible. Whereas in original Medicare, often the state has to pick up cross-over claims, a lot of what we do with our D-SNP is we buy that down and pay that state cross-over claim obligation. When somebody is in a Medicare Advantage program, the state is not going to see cross-over claims at all, whereas on the original Medicare side, they would.

That fiscal benefit to states -- I think in New Mexico, we're producing $6 million a year benefit to the state by just doing that.

So those pieces, I think, are typically not brought into these discussions as enablers, and I think the more we can illuminate that, it would help us then

determine where we want to weigh in on federal policy.

CHAIR THOMPSON: Alan? Alan passes.

Brian.

COMMISSIONER BURWELL: So I think one of the reasons why Arizona is at 46 and Virginia is at 16 is just time in the program. Arizona has been at it a lot more.

Karen also told me afterwards that when Virginia transitioned out of the demonstration back into just MLTSS and D-SNPs, CMS arbitrarily limited the number of Medicare beneficiaries that could be in aligned plans to 2,000, something like that.

COMMISSIONER BELLA: I got to correct that. I wasn't there, but it wasn't an arbitrary determination.

Unfortunately, it was found to be more cost effective to put those folks back into fee-for-service. So the majority of folks, all but 2,000, because of the benchmarks, the Medicare benchmarks, and the way the costs are calculated and the rural counties, it was a cost-effective issue, and so they did not cross-walk them into the corresponding D-SNP.

There's nothing arbitrary about it, unfortunately. It was actually calculated, which is almost

worse, because it's saying that we still think it's more expensive to put people into integrated products, but that was why, just for the record.

COMMISSIONER BURWELL: Okay. I'm just being the messenger.

I guess I feel like we should have a more extended discussion about what our strategy is here. I guess I'm in Melanie's camp that recommendations around continued investments and infrastructure may not be necessary and are relatively minor, and that our task is more on the real policy changes.

But there's so much that we could address. I'm not really clear how we would want to sort that out.

CHAIR THOMPSON: Well, that's the challenge, right?

COMMISSIONER BURWELL: That's the challenge.

I also think usually we develop recommendations in association with some kind of -- well, I'll say another thing. I think we would be more well positioned if we had more evidence behind us when we move forward and promote integrated models. So if these evaluations come out and show positive outcomes, that would be a very good time.

Third, we have our own internal -- we have work that we're doing. We usually tack our recommendations onto some work that we've done. So I would like to spend more time talking among ourselves about which direction we want to go in to have a strategy around this.

CHAIR THOMPSON: Well, let's at least maybe try to formulate a plan now. I don't know that we're -- I mean, we hopefully get smarter every day, but I think the purpose of our conversations last time and this time were to try to get at least a formulated approach to what we're maybe trying to focus on.

It sounds like -- let me just test the proposition. It sounds like there's one constellation of things, which is about taking stock of value and savings. Where do the benefits come from? What are the things that influence where benefits flow to members, to plans, to states, to the feds, both with respect to delivering coverage and benefits and with respect to savings? What is the state of the research about that?

I mean, we're not going to, obviously, have perfect answers on all of that, but I think there has been a fair amount of ground covered.

To the extent that both the federal government is trying to promote alignment and states are trying to take advantage of that alignment, based on those perceived values and benefits, are there key enablers and key barriers?

I think that it sounds like perhaps understanding the state of the barriers today, sort of picking up on Melanie's point, is where maybe people would like to spend more of the time, particularly if it's been a while, which it has, since we've tackled some of these issues and taken a look at them and ground has changed underneath of us in some respects and we've gotten more state experience, so to the extent that there are these kinds of issues that arise and that we may want to respond to, which would set us up to potentially make recommendations, maybe not, but certainly give us kind of an outline for a chapter.

Anne.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah I also want to remind you that we have three projects underway that will give us information that seems quite relevant to this. One, an inventory of what we know about integrated care models, the second on what states are doing in terms of

care coordination in their managed care contracts, and a third on factors affecting enrollment and disenrollment, we'll start having some of that for you soon, but probably not until sometime in the winter.

And so, I just want to remind you that that information is coming and it's new information that bears on these issues.

CHAIR THOMPSON: Thank you, Anne. I think that fits very much well within what we're talking about.

So any reactions?

COMMISSIONER GORDON: Anne, on the one I was talking about, care coordination, that's included in contracts, is that broad enough to encompass even like Anthem or MIPPA contracts?

MS. VARDAMAN: Hi. So yes, we have a contract underway right now with HMA and it's two phases. One is looking at the contract requirements between states and plans and what states are requiring of plans in terms of their care coordination standards. The second piece is talking to a variety of stakeholders -- states, plan providers, consumer advocates -- to understand kind of how things work on the ground, how states are learning, and,

you know, adjustments that they made over time. And for the contract review we are including looking at the states that are doing MLTSS along with D-SNPs and what their MIPPA requirements and plans look like.

CHAIR THOMPSON: Any questions, Kirsten or Kristal, about what we've said here in terms of thinking about some of these different buckets, which will obviously require you to think a little bit about what belongs where and what do we have now and how do these pieces come together in support of that and where might we have some gaps where we need to fill in?

MS. BLOM: I think we can talk amongst ourselves, based on what you guys have said, and come up with something.

CHAIR THOMPSON: Okay. Good.

COMMISSIONER BURWELL: So I just want to throw out, so you're saying we'll get the results -- we'll get these reports in for the February meeting? I'm just trying to create a scenario here, which would then -- and then we would have a couple of meetings to think about recommendations with maybe something more solidified at our last meeting in the spring, and something that we could

include in the June report? I'm just throwing stuff out.

EXECUTIVE DIRECTOR SCHWARTZ: So one of those we were going to have for January, or was it March?

MS. BLOM: Well, we might have the enrollment one for December.

EXECUTIVE DIRECTOR SCHWARTZ: Okay, for December.

MS. BLOM: And then the care coordination is a little bit later.

EXECUTIVE DIRECTOR SCHWARTZ: Yeah. I guess, Brian, the question is that, in part, whether you want to make recommendations that will depend upon what we evaluate from what we learn, and then to sort of think about what does that show in terms of an action step for it. It's a little bit hard for me to imagine that you could -- I don't know. Maybe on the December one something will bubble up, but if it's going to be a little bit later it's hard for me to imagine how you're going to have recommendations in this report cycle, although you might have a very robust discussion of some of the issues. But, you know, I could be surprised. Maybe something is going to pop out that's really glaring.

CHAIR THOMPSON: Or it may just be that, you

know, it's sort of a taking stock chapter with a lot of rich information that kind of puts us in a better position for next year. Again, I think we have to kind of see how it all comes together from a timing perspective.

Martha, you wanted to jump in.

COMMISSIONER CARTER: I'm trying to formulate my question, and we had a little conversation at the break, to the extent that the practices that -- the entities that managed care plans would contract with -- to the extent that they can help the success or not of these projects. Does it make sense to look at how -- what's the experience of that level of the health care system in these projects? And maybe somebody -- maybe you can help me elaborate that question, Chuck, but it does seem -- I don't know. I don't know that experience. I don't have any lived experience with that. But it seems like there are things that the plans can do to encourage support from the practices, from the hospitals, from the nursing homes, whatever it is that you're trying to contract with.

CHAIR THOMPSON: It seems like in that constellation of questions that we have about savings and benefits, the practice level needs to be part of that

frame.

COMMISSIONER MILLIGAN: But I think Martha's comment is a little broader. To the extent that patients trust their providers, the provider experience with MLTSS or D-SNP influences whether there is alignment, whether the member opts out. So I think it's kind of what are the factors by which the provider is an element of the success of a program that will help retain the membership inside of an aligned model.

CHAIR THOMPSON: Well put. Thank you.

COMMISSIONER CARTER: And to the extent that the care coordination is also helping or not at the practice level, at the health care provider level, because those are activities certainly that are happening at the community health centers' care management. But how are those activities then affected by what's happening in the D-SNP?

CHAIR THOMPSON: Any final comments from the Commissioners before we move on?

[No response.]

CHAIR THOMPSON: So, you know, we've given you a lot of things. I think what we're going to ask you to do then is kind of put that up against the current research

agenda and sort of see what you think we can pull together, what may need some deeper dives. I think there will be a couple of bites at this apple for this Commissioner group to kind of ask some questions and dive into some details where we think there might be some benefit to doing so. So we will look forward to those additional conversations.

CHAIR THOMPSON: Okay. Let's move on to the next subject and the last session for this meeting. Martha's going to end our October meeting with a bang on eligibility, enrollment, and renewal processes.

ELIGIBILITY, ENROLLMENT, AND RENEWAL PROCESSES: FINDINGS FROM STATE CASE STUDIES

* MS. HEBERLEIN: So no pressure there whatsoever.

As you all know, the Patient Protection and Affordable Care Act or ACA made significant changes to Medicaid enrollment and renewal processes, with the goal of making the program more efficient, reducing complexity and effort on behalf of enrollees and program administrators, and integrating Medicaid with the health insurance exchanges.

So in September of 2017, the Commission discussed these changes and expressed interest in examining the

status of state systems and processes used to support Medicaid program eligibility, enrollment, and renewal, and so today I will present the findings from that work.

So I will begin by providing some brief background on the changes made under the ACA before I talk about the case studies and the key themes that we found, and then I'll conclude with some of the things that states are looking forward to in the next few years before turning it over to you for discussion on next steps.

Historically, Medicaid enrollment and renewal processes relied on in-person applications and paper documentation to verify eligibility. States had considerable flexibility in designing and administering many aspects of this process, leading to variation across states and populations.

As mentioned at the outset, the ACA's changes to Medicaid enrollment and renewal were intended to simplify and streamline those processes for all populations. In doing so, there was an expectation that the share of eligible persons able to successfully enroll and retain Medicaid coverage would increase, and errors associated with administering complex eligibility rules would

decrease. In addition, these provisions were meant to ensure that determinations of both eligibility and ineligibility would be made more quickly and at less expense.

The ACA required states to maximize automation and real-time determinations with Medicaid and CHIP applications through the use of electronic verification policies, simplified business practices, and the use of multiple modes of application including online. The ACA also gave states broader access to third-party data sources through the Federal Data Services Hub and required states to use these data sources to verify eligibility whenever possible, instead of requiring applicants to document their eligibility.

Federal statute and regulations now define a more common approach across states for individuals to apply for, enroll in, and renew coverage, but even so states still have some flexibility in designing their processes.

MACPAC contracted with the State Health Access Data Assistance Center, or SHADAC, at the University of Minnesota School of Public Health to examine the post-ACA status of state systems and processes used to support

Medicaid eligibility, enrollment, and renewal for those whose eligibility is determined using modified adjusted gross income, or MAGI.

The six study states were Arizona, Colorado, Florida, Idaho, New York, and North Carolina. The study assessed autoenrollment and autorenewal practices, the use of electronic data sources for verification, and the degree of integration with non-MAGI Medicaid populations, and other public benefit programs. Interviews for this study were conducted in May and June of this year.

So these study states took different approaches to streamlining their Medicaid eligibility processes, which reflected their state priorities and existing policies, as well as the age and capabilities of their existing eligibility systems. Some states prioritized real-time enrollment and renewal, while other states prioritized eligibility worker involvement in the process. All states focused on the transition to MAGI-based eligibility rules and the use of electronic data sources for verification. They also had to balance the need for accurate eligibility determinations with efforts to make Medicaid enrollment as streamlined as possible, and this informed their decision-

making.

So, Commissioners, there are more details on the individual states in the appendix of your materials but I'm going to talk today more about the key themes that we found.

Despite their different approaches, the responses across the six states revealed several key themes related to Medicaid beneficiary and program experiences. Across the study states, respondents said that their combined online applications support greater access to coverage and reduced beneficiary burden. This is, in part, because with the single application individuals can submit required information just once rather than having to submit the same information multiple times through different avenues.

The combined application can also help raise awareness of other benefits for which individuals may be eligible. Respondents acknowledged that while their application pathways and systems are integrated from the customer point of view, the back-end eligibility systems are often fragmented, outdated, or complicated to maintain. However, all respondents said that their state systems increased the caseworker's ability to quickly and easily

get a holistic view of their client's program participation, and this has helped to reduce or shift workloads for eligibility staff, especially for those serving individuals who receive multiple benefits.

Respondents all agreed that the system connections with electronic data sources, including state, federal, and proprietary data sources, facilitated real-time eligibility determinations and auto-renewals.

States ranged from having connections that allowed workers to view electronic data in a central location, to having more sophisticated linkages were data populate state information systems directly. In addition to supporting the real-time determinations and more efficient application process, these interfaces allow for more timely notification to counties, meaning that in county-administered Medicaid programs workers can more quickly begin to work those cases that are also eligible for other benefits.

Assisters in multiple states also praised the online application together with the integrated eligibility system and use of electronic data for speeding up processing time. However, despite these robust rules

engines and electronic use of data, verifying income still remains one of the biggest challenges for states, as some beneficiaries, particularly those with unstable incomes, are required to provide additional documentation.

Most respondents remarked that the efficiencies gained through the data interfaces reduced the administrative costs and the fluctuations on and off Medicaid, thereby improving the continuity of care.

Respondents emphasized that even with the right data sources, a robust rules engine to automate the eligibility rules across health and non-health programs was critical to supporting their streamlined determinations. Several respondents explained that the systems support a quality control step as well, whereby workers can review how customers entered information and make corrections if needed.

In addition, some respondents felt that it supported a more efficient process, because a robust rules engine was seen as supporting better customer service as well. This allowed eligibility workers to focus on the customer and their specific situation instead of the

minutiae of the program rules themselves. The respondents did feel that policy knowledge was still important for eligibility workers to flag areas where there may be concern as people were applying for benefits.

So updating eligibility engines to accommodate the different program requirements in one system still remains challenging. Other programs often have different income-counting rules or stricter verification requirements.

States also struggled with designing a single streamlined application that could collect information in a straightforward, easy to understand way. Several states had structured their online applications so that they are dynamic, meaning that additional questions appeared depending upon the information that is already entered. Other states have struggled with combining their application information.

Respondents uniformly agreed that the streamlined processes, including a combined online application, are helpful for people to apply for Medicaid or other health and human services. However, in-person assistance remains in high demand, especially for certain populations such as

families with multiple sources of coverage, immigrant applicants, and individuals with lower computer literacy. Applicants come to the state or community assister offices typically because they lack computer access, have difficulty understanding the application questions, need help interpreting the notices, and need assistance with documentation.

So looking forward, respondents were closely monitoring potential Medicaid policy changes in their states, such as Medicaid expansion proposals in Idaho and proposed work requirements in Arizona. Also on the horizon are changes to several key funding streams, including an expiration of the Office of Management and Budget's Circular A-87, which everyone should know. It's a cost allocation waiver that is expiring on December 31, 2018. And when that waiver expires, states will have to charge human service programs for any efforts to integrate eligibility, enrollment, and renewal processes across health and non-health. Also forthcoming is a $26 million reduction in CMS grant funding for ACA navigator programs, as well as reductions to the federal medical assistance percentage for the Medicaid expansion population.

Four of the study states also reported beneficiary confusion regarding the correspondence about eligibility terminations and renewals, and three of these states reported plans to either improve the readability, allow notices to become more case-specific, or provide assisters access to the notices.

States are also continuing to invest staff resources and funding to improve the application and eligibility systems. All six states are working to improve the usability of application platforms for individuals, and all were also in the process of enhancing their eligibility systems, for example, through the integration across health and non-health, or moving away from legacy mainframe systems to rules-based systems that are modular, cloud-based platforms.

So staff is working with a contractor to publish these findings, but the Commission may have additional ideas for work in this area and we would be eager to hear what they are. And with that I turn it over to you guys.

CHAIR THOMPSON: Wonderful. I do know A-87, kind of inside and out, unfortunately, so I can't imagine that other people would not have spent, you know, lifetimes

thinking about this.

I just want to make a couple of points. First of all, I would just say my view. We should publish this. I'm not sure that there's a ton of additional follow-up that kind of jumps out at me in terms of prioritizing where we're spending our resources, but I think it's very helpful to kind of have done this and have a state of play. This is one of those areas we talked in the earlier session about, you know, sometimes you've just got to keep making incremental progress around some of these issues, and I think that's an area where we see states continuing to invest resources and so forth.

You know, obviously if other Commissioners have some ideas about some jumping-off points for additional inquiry, please jump in.

I just want to make a couple of comments about things that I think merit reinforcement. One is the importance of user-centered design in these technology projects and the idea that you really have to be putting yourself in the members' place, and, Leanna, I see you nodding your head about the idea that, you know, some of this, you know, is not intuitive, you know, the way that

things flow is based upon how the government side processes something or the existing workflows that have kind of just been built up over time rather than from the standpoint of the member.

And, you know, just re-emphasizing that, you know, when we think about any kind of modern technology project today, where people, consumers, workers have to navigate through a website, that element of designing with the users, watching them use the websites, determining where they get stuck -- there's all kinds of tools and analytics that can support that. And I'm just really gratified, first of all, to see, you know, some of these states really embracing those concepts, and I think that really pays off in the end.

And then, secondly, kind of the point that regardless of what kind of technology, regardless of how well it's designed and what you've invested, people still need people. And I think just those two themes really jump out at me. And, you know, it's sort of interesting having this presentation on the heels of the conversation that we had yesterday about, you know, work requirements and the kinds of things that we think, you know, the states and the

federal government ought to be sensitive to. And I think those are a couple of points to be brought into that conversation.

Toby.

COMMISSIONER DOUGLAS: First, great report.

I mean, I would say, this area, we forget how important this work was when we think of the modernization of Medicaid, and, well, OMB's Circular 87 seems such an arcane -- it was so important in terms of modernization and the experience.

So one area is just around the consumer experience from having -- if we or we think there's enough out there just in terms of how its impact, the experience of eligibility enrollment, from the beneficiary perspective and changes. I mean, one would be understanding, for example, back to where beneficiaries -- we know most of Medicaid beneficiaries now have mobile phones. So what are states doing in moving more to not an online, but thinking this through mobile devices and changes in that structure? That would be something to just understand kind of the experience and how it's changing.

The other thing from a state perspective -- and

Penny and I know this was the big one as well -- we still need the workers. It wasn't underlying -- and you said around cost, and it wasn't clear on where we're seeing changes in administrative expenditures. That one of the goals, especially back to OMB Circular 87 was to reduce the administrative expenditures, knowing the technology and consumer ability to actually do the enrollment, whether through more of an assister rather than eligibility workers would change it and if any states are seeing that change.

MS. HEBERLEIN: So we didn't ask specifically about whether or not there were cost savings.

We heard that states were shifting workers because they didn't have to spend so much time so that they could then spend time on the more complicated cases because people were coming through a more streamlined process.

We heard that the data interfaces in some states that now -- even the state that aggregated their data into one computer screen -- that eased worker time because instead of having to go from this screen to this screen to this screen, they could see everything at once. Even though they were still manually sort of approving the case, they were moving it through more quickly.

We heard tidbits that would make you think that there are administrative savings, but we didn't specifically ask where the dollars associated with that, where they may be coming from.

COMMISSIONER DOUGLAS: Maybe this is just more of my own, but I feel like this is something that we should dig deeper. Over time, if there are not, if we're still seeing the same eligibility enrollment infrastructure, it just seems something should have changed, and I'd like to hear Penny or others on this.

CHAIR THOMPSON: Well, I would say, unsurprisingly, I mean, there was a theory of the case --

COMMISSIONER DOUGLAS: Yeah

CHAIR THOMPSON: -- that said there would need to be this investment, and there would be back in savings. Those savings were largely technology-based, not people-based, which was the idea that the ongoing maintenance of those systems would be lessened in the future. So they would be less costly to operate.

COMMISSIONER DOUGLAS: [Speaking off microphone.]

CHAIR THOMPSON: Right, right. I'm not saying there wasn't a reflection of automation, but in the -- both

the regulation, federal regulation was all technology, not people.

Unsurprisingly, I don't know that we have good baselines. So when we're sort of saying what was the change, I think that we've not always -- administrative data has not always been reported in a way that allows CMS to easily break it out and then to be able to distinguish between people working on this versus that or even technology pieces that support this versus that. So I think it would be a very difficult task to try to really pull that apart.

I do think it's kind of interesting that people -- because I think this was the idea -- that if people were released from -- and this is, of course, part of the argument around technology. If people are released from mechanical calculations and collections of paper and really have an opportunity to devote their time to people who need more assistance or education, that that would be, as we used to say in my OIG days, funds put to better use as opposed to a big part of this being extracting personnel costs out of the system.

I did want to respond, Toby, to your point about

-- I kind of think about this as almost consumer engagement, this question about how do you reach consumers. There's a whole lot of reasons why in today's world, we might want to be able to reach and engage Medicaid members, consumers, beneficiaries, applicants, and what are the methods by which people are finding success in doing that, what kinds of communications and education and messaging. There's a bunch of stuff around texting. It is a slightly different subject than eligibility, though it could take into account anything that you need to do to maintain your coverage, but that may be an area worth exploring.

Martha.

COMMISSIONER CARTER: As I alluded to yesterday, I seem to be sort of inserting myself in this middle ground here. When the marketplaces first went into effect, the community health centers received additional funding for eligibility and outreach workers, and for some period of time, each health center got some amount of funding. For some period of time, we actually were reporting quarterly in terms of the number of people who were assisted, the number of people who were informed. I don't remember the metrics anymore, but that funding has gotten rolled into

our base grants.

So the community health centers, the FQHCs -- there's a little difference, so I'm going to use community health centers -- continue to get this funding to have staff to interface with our patients and the community over enrollment issues. There's a certified application counselor designation that requires training and certification that the health centers are now responsible for ensuring that that happens. So there's a whole wealth of information around that whole system that's somewhat limited to the health centers but not because those outreach and enrollment specialists are expected to go out in the community and hold public information events and help people enroll.

CHAIR THOMPSON: Alan.

COMMISSIONER WEIL: I thought this was really interesting. I had some involvement in this topic at the beginning and have been away from it for a long time, so it's nice to get an update.

I too, Penny, struggle with what comes next. At the risk of grossly overstating it, you made a few comments about elements of what make it successful.

We just had a conversation about duals, and a lot of the same elements -- time, infrastructure, resources, personal touch, cross-state learning -- it's not rocket science. I mean, it is rocket science, but we know what it takes to build the rocket. Maybe that's a better way to say it.

So I really view this as a success story in two respects. One is the uncertainty regarding actual people use notwithstanding, the progress not just reported by these states, but in general, seems to me to be notable. But it's also the reality that, as what you presented reminds us, where states went with this was quite different, despite a consistent overall need to implement the MAGI rules. What it took to do that and what the emphasis was in the opportunity that created was quite different, and I think that's where you get some benefit.

So I'm not sure what to say other than I do think it should be published, but I also think it's important as we're looking -- sorry to turn a positive into maybe a less positive, but as we're looking at questions like public charge and work requirements and other things that go -- regardless of the merits of the policy, they go in the

opposite direction with respect to simplification, and if we can't sort of talk about the benefits of simplification, then I think it's very hard to talk about the implications of things that are not as simple.

So that to me feels like an important lesson out of this, which is sort of setting a bit of a baseline of it is -- this is -- it's a complex system in many dimensions. It is possible to simplify. It actually takes work to simplify, but then that simplification is also fragile because we don't stand in one place, and we want to do other things.

CHAIR THOMPSON: And keep breaking it apart, right.

COMMISSIONER WEIL: But then that has consequences.

Somehow, I would like that to be captured --

CHAIR THOMPSON: Yeah.

COMMISSIONER WEIL: -- because I do think there's a real lesson here.

CHAIR THOMPSON: I absolutely think there's like a throughput of themes here around consumer-friendly, user-focused, reducing complexity, and promoting automation to

free up people from spending time on mechanical, calculable matters.

But I do think, Alan, that point, which is there's always that constant strain of thinking about how to maintain that kind of an approach, this happens with benefits too. You get into a program, and you say, "We want this." Well, then what about this tweak and add this and do this? And suddenly, some of what you've tried to establish falls apart. So I think that's worth continuing to emphasize.

Any other comments from the Commissioners?

[No response.]

CHAIR THOMPSON: Let me invite public comment to this subject to any others that we've tackled this morning.

PUBLIC COMMENT

* MS. BRANGAN: Hi. I'm Normandy Brangan, and I'm with the federal Office of Rural Health Policy at the Health Resources Services Administration.

As you all plan your chapter on the duals, I ask that you keep in mind, as this discussion did today, some of the unique challenges of establishing health insurance markets in rural areas.

HRSA's national Advisory Committee on Rural Health and Human Resources published a brief in August that laid out some of the challenges of rural health insurance markets and some recommendations.

Thanks.

CHAIR THOMPSON: Thank you for that reminder. Excellent.

Any other comments?

[No response.]

CHAIR THOMPSON: Martha, thank you for this presentation on this subject, and we'll look forward to seeing that come together in a published issue brief or the chapter itself being published, however you want to handle that, but I think we all agree that this is really good information that we should make available to people.

Thank you, Commissioners and staff, for a great October meeting, and we'll see everyone back in December.

[Whereupon, at 11:24 a.m., the meeting was adjourned.